PUBLIC HEALTH NURSING

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EDITORIALS

A SEASONAL TRADE?

Is public health nursing subject to seasonal fluctuations? It certainly is. Ask any nursing group (except the school nurses) if September and October are not their lightest months and February and March their heaviest! Morbidity reports bear out this impression. There is actually less illness in the early fall than at any other time of the year. Opinion differs as to why this is so. It may be the beneficial effect of vacations, the lessened stress and strain in most jobs of summer production, the larger doses of sunlight every one from grandmother to the baby has tried to secure, less crowded living conditions, out-of-door life and exercise, fresh fruits and vegetables, the cumulative effect of all of these—and we must of course credit the control of communicable diseases—especially typhoid—as one cause of our healthy Septembers.

This lightening of the sickness load in early fall gives the public health nurse a welcome chance to review and plan her work for the busy months ahead. Here are some of the activities she may well finish up now before the new cases start coming in. Some of these duties apply to the nurse working alone, some to larger staffs.

1. Check all demonstration material. Order or prepare fresh, contrive new methods to display it
2. Clean old posters, order or plan for new ones
3. Check all educational literature. Re-order or secure new, re-label
4. Review all current records, follow-up those long unvisited prenatals and well babies. Make the postponed dismissal visits to convalescents, check on post-partum examinations among recent maternities
5. Review, revise, re-copy staff techniques, checking with latest in N.O.P.H.N. publications
6. General overhauling of office, clinic or conference rooms with view to repairs, renovations or re-arrangement
7. Check office reference books, list new ones needed, check with local library on supply of health education material
8. Plan and outline programs for group meetings for the year, including staff; mothers' clubs; committees, etc.
9. Plan other special meetings—annual meeting can be planned *in general* now
10. Visit new health activities in the city, county or nearby city
11. Review and bring up-to-date all information on clinic hours, hospital and sanatoria admission requirements
12. Study relationship to other social and health agencies and visit to strengthen understanding of joint plans for the coming months
13. Visit new workers in city or county and exchange program information
14. Visit board and committee members and promising lay people to interest them in the progress of the work
15. Catch up on professional reading
16. Make appraisal of work, checking with A.P.H.A. and N.O.P.H.N. appraisal forms.

NATIONAL CONFERENCE OF SOCIAL WORK MEETING

THE program of the 62nd annual conference of social workers weighed six ounces in printed form, lasted eight days (and nights) and offered more than two hundred papers to the 6,000 people assembled in Montreal during the second week of June! The executive secretary of the conference, Howard Knight, and our Canadian hosts had arranged every mechanical detail to perfection, so that the crowds were handled smoothly, pleasantly, and in the best "coöperative spirit." The new plan of combining health interests with groups working in allied fields was apparently satisfactory to every one and while very few public health nurses from the United States were present at the conferences, there were enough meetings dealing with general health problems to make attendance worthwhile. Birth control, health insurance, health education in school and camp, social hygiene, and community organization were some of the specific topics claiming attention from the health groups, while the broad topics of relief, social security, the economic crisis and world peace, filled our evenings.

One of the most discussed and timely topics occupying the thoughts of *all* groups at the conference was the subject of lay participation in social work. The National Committee on Volunteers in Social Work had joint meetings with such groups as the American Public Welfare Association, Family Welfare Association of America, Social Work Publicity Council, National Y.W.C.A., and at the meeting with Section III Community Organization, there was an entire section on "Community Planning for Volunteer Service." However, at many of the professional sessions, the subject of developing citizen participation and more community interest was brought out again and again. One state program of public welfare reported that it had become a statute that no local, county, or state relief program can operate without an administrative board of lay people.

The general tone of the conference was not very optimistic. All will not be quiet along the social work front for some time to come if we are to believe our leaders, but offsetting every gloomy prediction, standing out with a clarity and decision that reassured every listener, was a spirit of confidence in the social workers' ability to meet whatever situations arise. The past five years have been a test of adaptability, flexibility and perhaps—magnanimity. Mistakes have been legion, delays almost disastrous, but we still have a vast fount of courage for experimentation, of zest, and a will-to-win. We face the future without fear.

EVELYN DAVIS
DOROTHY DEMING

HEALTH TODAY AND TOMORROW

FOR THE first time in its history, the National Health Council—of which the N.O.P.H.N. is a member agency—is undertaking a nationwide effort to bring health and health facilities to the attention of every community. The slogan "Health Today and Tomorrow" has been chosen as the central theme of a campaign which will take the form of local town meetings to be held in the Fall in large and small communities throughout the United States. The N.O.P.H.N. has sent letters this past month to all its corporate agencies announcing the campaign and urging them to participate in whatever plans are made locally. More detailed announcement of the program will appear in September.

Student Experience in a Public Health Nursing Agency*

By RUTH W. HUBBARD
Director, Visiting Nurse Society, Philadelphia

A SATISFACTORY answer to this question would solve, at least temporarily, one of the most pressing problems in the field of nursing education, as far as those of us who are engaged in public health nursing are concerned. A generation ago public health nurses, enthusiastic over what they felt to be the educational values in their realm, besought directors of schools of nursing to release their students for affiliations in this newly developing field.

Hesitatingly, at first, dubiously perhaps, with difficulty always because of pressure within the hospital walls, directors experimented with their enthusiastic colleagues, sending first an occasional student, then a regular group, and finally in some instances, the entire senior class to the local public health nursing agency for a period ranging in length from two to four months. In the beginning the objectives of the school directors in this departure were vague and inarticulate. They had heard of something called a public health point of view. They discovered that students who had been "outside" sometimes returned with an understanding of their patients and an awareness of illness as an experience with many ramifications in family life that did not always develop during the hospital experience. Something had been added to the student—just what it was or how it might help her in her future work was not always clear. Meanwhile, the public health nurses urged affiliations. This field was developing rapidly—new workers were needed—many were learning "on the job," and those who had had some introduction as undergraduates were in demand. The affiliations continued. They increased in number and the volume of students receiving the experience grew likewise. In some places nurses said that every student should receive this service during her training. Others believed that it was valuable only for certain students—*i.e.* those definitely planning to enter community nursing; those with particular preparation; those with special aptitudes. Wide variation developed in policies governing the selection of students for this experience. Likewise differences obtained in the preparation of the student before her affiliation, the experience offered her in the public health field, the educational program provided by the agency and the assumption of responsibility for the expenses involved.

By the time that the Survey of Public Health Nursing was published in the spring of 1934, and the League began its revision of the standard curriculum in the fall of the same year, certain procedures concerning affiliations in public health nursing were generally accepted as desirable although not carried out universally. It was considered advisable for the student to have had certain clinical services prior to this affiliation, as general medicine and surgery, obstetrics, pediatrics, diet kitchen, and if possible dispensary. She was to come to the public health agency in her senior year, spending a period of approximately two months there and being at the time wholly free from responsibility for service in the hospital or class work in her school. The public health nursing agency was to offer a planned program of observation and experience, providing an instructor upon whom rested the responsibility for the student's experience and supervision. Reg-

*Presented at the Annual Convention of the National League of Nursing Education in New York City, June 6, 1935. Printed simultaneously in the *American Journal of Nursing*. Reprints of this paper will be available.

ular classes, demonstrations, case conferences, written work, formal reports to the school of nursing, the provision for joint conferences between the teaching staff of the schools and the public health nursing agency were all accepted as fundamental to a sound student experience. The Survey showed those of us in public health nursing that we had achieved this standard in part only. The new Curriculum Committee challenges us to set even richer objectives for achievement. Today, schools of nursing are increasingly asking for this affiliation for their students. State Boards of Nurse Examiners are urging—even requiring it—as a means of enriching the clinical experience offered by certain schools. So incompletely have some of us understood the purpose of such an activity that within the last few years occasional public health nursing agencies have thought tentatively of affiliations as a means of augmenting falling staffs, while others long associated with student work and fully appreciating its value have reluctantly restricted their intake because of inability to bear the expense of the necessary teaching staff. Schools faced the problem of meeting in whole or in part the financial outlay of an affiliation for their students have questioned their ability to do it and have begun to search for other answers to their needs. Schools meeting refusals to their requests for student openings in public health nursing agencies whose standards they approve have been faced with the problem of what to provide as an alternative. Generally speaking, private rather than public agencies have been involved in this participation in nursing education. Few public agencies have had in the past adequate educational personnel to undertake such teaching responsibility. Obviously, the schools have been faced with difficulties of selection. How could the school evaluate its prospective associates in educational responsibility? Likewise the public health nursing agency has been troubled. Volume alone has prevented it from accepting all students from every school. How should the field organization evaluate the schools who desired its assistance? How should it determine when to accept and when to refuse?

THE HEALTH APPROACH IN NURSING

May I set before you the objectives we have accepted for this part of the student's education that we may see if they are to be attained only in a public health nursing agency?

It has been our desire, first, to give the students some understanding of both healthy and sick individuals of all age groups in their own homes, as a basis of wider understanding of human problems; second, to extend their knowledge of the health and social factors in family and community life relating to the maintenance of health as well as the development and treatment of disease; third, to increase their familiarity with existing community resources for the prevention and control of disease; fourth, to help them to adapt hospital methods to the situations and equipment found in homes; fifth, to teach them how to approach the family and help to make the adjustments needed to maintain health and to facilitate recovery; and finally, to enlarge their experience in relation to conditions and stages of illness seldom seen in the hospital. In other words, we are interested to give the student what might be called a *health approach* in nursing. We wish to increase her skill and knowledge in the promotion of health as well as in the care of sickness. We desire to enable her to use this skill for those individuals and families with whom she comes in contact to prevent illness through health education. We hope that such an experience will enable her to see more clearly the place of nursing in the community health program whether it be in the hospital, clinic, home, school, health center, or the industry. We are eager to have her see nursing as a part of a great movement which permeates the entire community rather than as an isolated activity occurring in certain carefully constructed situations.

These objectives seem far reaching and have been set with the public health nursing agency definitely in mind as the field for experience. However, when they

are explored carefully, it is evident that much that is set up in them can be achieved in other experiences now available to the student. With the exception of the objective which gives the student experience in helping families to adjust to the problems of illness within their homes, the aims stated above can be integrated into the undergraduate experience available within the hospital and dispensary walls. We have said that we desire for the student the public health point of view. To define the term is not easy, but to most of us a public health point of view assumes an ability to regard the patient as an individual having a family to whom he will return following his illness and with whom he will take up his life again. The relationship between sick and well individuals in their family life is of great importance to the health of the public in any community. A public health point of view implies a knowledge and understanding of the fundamental principles of community health. And there follows upon this an appreciation of the importance of each individual's welfare in the health picture of the community as a whole.

The student in the school of nursing is concerned with the acquisition of knowledge which will enable her to minister successfully to the needs of those patients under her care. She is equally desirous of adding to her equipment knowledge of disease, its prevention, cause, manifestations, treatment, prognosis. Her major interest lies in the acquiring of this knowledge and its use in the performance of services which will benefit those about her, giving her at the same time the confidence of experience in her chosen field. Only recently have we included in our objectives for the undergraduate the desire that she shall acquire not only a knowledge of how to care for the sick herself but also how to teach others to give this service, and even more important the knowledge of how to enable others to prevent the onset of illness in themselves and their associates. In the field of public health nursing, we have been concerned with this responsibility for teaching by the very nature of our activity. From the beginning of the movement, the nurse has been a visitor rather than a permanent member of the household. In a large part of the field she has been a visitor at such rare intervals that she was unable to assume responsibility for any regular part of the care of the sick individual. Early in her career she discovered how frequently illness was the result of lack of knowledge. Therefore, she was impressed with the need for positive rather than corrective teaching only. Many public health nurses have learned through trial and error such skill as they now possess in the art of teaching. For their young professional sisters, they desire the early acquisition of these skills and knowledge for the benefit of the nurse herself and for the equal benefit of future patients.

SHOULD THE AGENCY BEAR THE ENTIRE RESPONSIBILITY?

The hospital is a very busy place. The student is surrounded on every side with a wealth of new information which she desires and needs to master. To integrate this additional point of view throughout her undergraduate experience is a task which cannot be laid upon the already heavily burdened shoulders of her instructors. There are those of us who feel that in sending a student to a public health nursing affiliation in her senior year and requesting that she be given experience to achieve the objectives listed above, we are asking much of a community agency in terms of intensive experience for the student. After many years of study, we are wondering whether an affiliation in public health nursing is something like the frosting which is set upon a cake. We wonder whether the cake would be better if the ingredients in the frosting were mixed with the batter and a different result obtained. If it is important for the student to understand the value of health teaching; if it is important for her to think in terms of health as well as in terms of care of the sick; if it is desirable that she have knowledge not only of the acute stage of illness, but also of the onset and period of conval-

escence so difficult for many individuals; if her appreciation of the place of nursing in the community is vital, why do we wait until her senior year, giving her then a very short intensive experience to supply these needs? It seems to me that we can wisely ponder this question and that the answer may appear in the action which certain schools have taken by adding to their faculties a public health nurse upon whom is placed the responsibility for the achieving of our objective throughout training. In those schools where such a person has been added, the methods used have varied. So they will vary if other schools accept this suggestion. But however it is done, the ultimate success will rest upon the ability of the public health member of the faculty to see and use the myriad of opportunities already existing in the hospital and the dispensary for the student to see the patient as an individual, as a member of a family, who desires to be taught; who prefers health to illness; and who has a long road to travel to attain that health after he leaves the hospital.

In all nursing we have been concerned with setting up satisfactory methods of procedure. Since the hospital has been our environment we have been interested chiefly to set up these methods of procedure in a manner satisfactory to the hospital. The Curriculum Committee tells us that it is considering for its objective, the aim of adjustment for the ideal nurse. One of the things which we have been greatly interested to give the student in her public health nursing affiliation has been the ability to adjust to the home environment of the patient. If we are anxious to give her this ability, we can provide for it in her training whether she has experience in a variety of homes or not. The public for whom we exist, has been known to say that the average nurse cannot adjust to the average home. We know that this criticism is frequently just. Whether the student plans to go into community work or desires to enter the field of private duty, if she chooses institutional work or plans to become an administrative person, she will be called upon throughout her professional experience to adjust frequently and successfully. Therefore, so vital an objective can well be planned for earlier than the senior year.

We have sent her to the public health agencies to learn to teach because we believe that teaching is a part of the function of a nurse. Yet, while in her hospital experience she has been confronted with opportunities for teaching equal if not superior to those which she meets in the home. Why do we wait until she goes outside the hospital to give her any equipment for this major function?

OPPORTUNITIES WITHIN THE HOSPITAL

If we agree that our objectives may be applied to the entire course in nursing and not to the public health nursing affiliation alone, then our concern lies not with how to secure a public health affiliation, but how to achieve these aims either through affiliation or without it. Let us face frankly the fact that as educators we are responsible for the whole of the student's preparation and not only for that which takes place within our hospital walls. We cannot rest comfortably believing that all we desire her to have will be "added unto her" at the Visiting Nurse Association. We must be intimately acquainted with the procedures used in the public health nursing organization to inculcate the point of view we crave. A poor affiliation is infinitely worse than none. An organization which does not provide carefully for a supervised orderly experience for the student may be more harmful than helpful to her. Even if it is doing admirable work as a service agency, it may not be equipped to undertake a nursing education responsibility. Beginning at home, therefore, what can we do? We can add a public health nursing instructor to our faculties who will assist in integrating the health point of view throughout the course. She will find a wealth of opportunity in the ward and the dispensary. We can perhaps provide some field experience in a sound public health nursing agency for our instructors and head nurses so that they will be able

to base their teaching of patient and student upon actual knowledge of home situations. We can certainly secure for our students observation trips with field agencies to visit patients they have known in hospital or clinic, thus making the excursion an experience with real purpose readily apparent. The student who visits her convalescent cardiac patient at home, climbing three flights of stairs to the apartment realizes far more acutely the importance of the oft repeated direction of the physician, "stairs once a day only," than when she simply goes out with the public health nurse to see patients in general. If the visit is made to the home of a mother with her first born, who learned in the hospital to bathe her baby, the student is keenly interested to see how practical her teaching was and is alert to add suggestions in her next group based upon the home visit. The visit with the school nurse to the home of a former pediatric patient with diabetes enables her to realize how carefully the dietary instructions must be given in clinic if a mother already responsible for a household of six members is to find her new program practical, even before the prolem of teaching the child to eat the prescribed food is approached.

Within the hospital set-up there exist marvelous opportunities for learning how to teach the clinic patient both in the dispensary and in the follow-up program of home visiting carried on by the dispensary staff. Such a follow-up program should not conflict with existing community agencies, and students accompanying the staff worker in the home should be carefully guided by an instructor familiar with the community program. We can include in our case conferences and faculty meetings a member of the educational staff of the local public health nursing agency, thus truly sharing with that organization our mutual problems in the student program.

EDUCATION BASED ON SOUND SERVICE

The hospital has a long history of association with educational programs for both medical and nursing students. The public health nursing agency came into being first as a service organization alone. Its recognition of its teaching opportunity and responsibility has come more recently. Aware now that it has a real place in the realm of nursing education the agency must remember always its first obligation to the public to whom it has agreed to offer graduate nursing service. For this reason public health nurses talk about ratios of staff and students, they murmur over saturation points and they raise questions about an adequate teaching and supervisory staff to meet not only student needs but also to insure satisfactory patient care. In other words, they cannot honestly forget their obligation to offer sound community service. Only when an agency is offering this sound service is it a desirable field for student experience. An educational process to be valid must be based upon a sound service program. No alternative is worthy of the effort involved.

These observations upon historical development and our groping aims in present practice summarize themselves readily into certain factual statements. A public health nursing affiliation with a well organized public health nursing agency does give the student a wider understanding of illness in the individual, of the value of health and education for health, of human relationships in illness and health and of the place of nursing in the community health program. A public health affiliation is not the only place that the student can gain this knowledge. It would be valuable to have the student acquire this point of view concurrently through her training rather than in an intensive dose at one time only. The inclusion of these objectives in nursing education presupposes provision for adequate teaching personnel either in the field agency or the school of nursing. This acknowledges expense, an expense that the school of nursing should be willing to assume. Clinical education to be sound must be based upon sound community service. The fact that an agency offers good service does not mean that it can automatically offer students valuable experience. But it does mean that a rich

student program can be developed in such an environment if those responsible are interested to do it. Not every public health nursing agency is ready to take students, no matter how eagerly the schools request an affiliation. Some excellent services may be too small in size to warrant the addition of necessary personnel. When a school seeks an affiliation in public health nursing it wants to be sure that the agency approached can offer that experience more satisfactorily than any other resource within or without the hospital. The school with no public health agency available need not be discouraged. Upon examination it may find rich resources of experience in its own clinics. These may not be ready for students immediately but with careful development they may become valuable sources of student experience. The thing we desire for our students in a public health affiliation is neither simple nor inexpensive and wherever we secure it the results to be achieved are worthy of sincere effort and investment.

PIONEER WORK STILL NEEDED

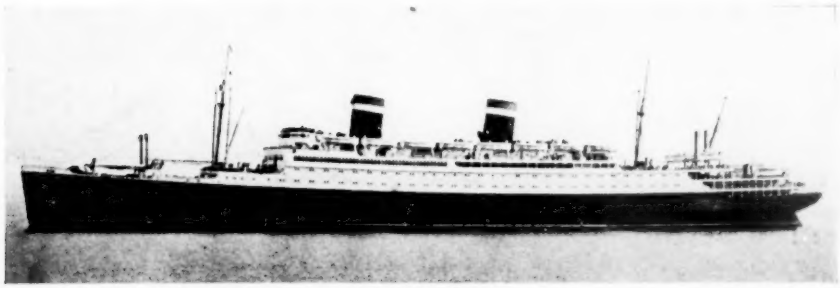
Is there then an answer to the question raised by our topic? Yes, I believe there is, but it is not a clear-cut direction which says proceed by these steps. Rather I hold that we are faced with the opportunity for new pioneer work. It lies before us to rewrite our objectives for the health approach in nursing and then to proceed in countless ways to work out for each school the best methods of achievement possible. There will not be a uniform procedure but there will be uniformity of purpose and a universal eagerness to find and use opportunities presented by each situation. It is characteristic of the pioneer that he has the courage to advance into unexplored territory. He is ingenious also and can devise ways for meeting his needs. At present by no known means could every undergraduate student receive an affiliation with a public health nursing agency. But every student can receive experience to help her realize the objectives of an understanding of health in nursing, and public health agencies can and will adjust their educational programs to meet the need of that new group of students who come out from the school of nursing seeking an opportunity to follow closely certain individuals or families in whom they are as students vitally concerned. The affiliation as we know it today will change. It is serving a purpose in awakening public health nursing to its educational function though that educational program may take a new form in the future.

As the pioneer is courageous so he is also fundamentally honest. In the matter of the public health affiliation let us be likewise foursquare, building our plans for this educational experience only upon sound service programs in hospital, clinic or field agency; being concerned first always with the welfare of the patient; placing the student under the direction of adequately prepared and truly understanding instructors; and advancing steadily through enlarged experience and vision toward the realization of all that is implied in that broad objective—health in nursing.

An Ounce of Prevention at Sea

By ALICE M. ELLIS, R. N.

S.S. *Manhattan*, United States Lines



Courtesy United States Lines **S.S. Manhattan**

EVEN in my wildest moments I never imagined I should ever be in a position to talk on this subject. Life certainly plays strange tricks with us mortals. At the end of December, 1931, "Old Man Depression" put me on the outside looking very forlornly for a job. Three months of looking and still no place in the sun; then, I met a thrice-blessed friend, who arranged a meeting for me that resulted in my signing the Ship's Articles as Registered Nurse of the S.S. *Manhattan*, living happily ever after.

But we must begin to talk about prevention of illness, accidents, and the maintaining of cleanliness on board a modern ship at sea.

The voyage from New York to Germany and return, via Ireland, England and France, lasts about three weeks. In this space of time the captain, with his officers, holds four "Fire and Boat Drills." There are fire stations in all parts of the ship. Each is numbered. The alarms are rung from the bridge. Everyone counts the number of strokes. Then, there is an increased activity, quiet and orderly, amongst the crew, who hurry to the part of the ship assigned to him or her, reporting there to the officer in charge of that particular station. For instance, the chief surgeon goes to the hospital. His assistant, with two male attendants carrying a stretcher and first aid kits, go to the scene of the fire; while I get to the hospital quick as quick. These drills are held so that we may be letter perfect in our duties if on some unfortunate day fire or any other direful tragedy should occur. Breathes there a nurse who has not envisaged, foreseen and feared such an emergency in any hospital? And we are on the sea! It behooves us therefore, to be even more careful to look, watch and listen. Should an accident occur, we are ready to act quickly, calmly and effectively, making every motion count. How do we know our stations? A fair question. Every employee aboard the ship, in no matter what capacity, is given a card (see illustration) which tells just where he or she is to report.

UNITED STATES LINES
CREW STATION CARD

DECK DEPARTMENT

S. S. Manhattan
Date April 10th, 1935
Name Miss A. Ellis
Rating Nurse
Articles No. 16
Boat No. 16
Bulkhead Door Section
Fire and Emergency Station At Hospital
Initialled H. D. P., 1st Officer

The first afternoon we are at sea the

captain meets his passengers in the Grand Salon and talks to them on safety measures. This speech is broadcast throughout the ship so that Tourist and Third Class passengers may listen. He points out to them the need of speed and calmness in face of an emergency, asking them to pay particular attention to safety rules, bringing to their notice the framed safety directions in their staterooms. These instruct the passengers where to find lifebelts, how to adjust them and give the number, with position, of lifeboat to which they are to go in case of necessity. In each stateroom there is also a framed notice cautioning passengers not to handle the portholes, which are heavy, but to summon the steward to adjust them as desired.

GOOD HOUSEKEEPING AT SEA

The captain, chief officer, pursers, both surgeons and chief stewards go on inspection tours all over the ship each day at sea, as well as an hour or two before leaving port, east or west bound. These inspections are made to finetooth comb the ship for any defects in safety devices, cleanliness and sanitation. A further inspection is made by the captain and chief engineers. This is too technical for my understanding, but has to do with navigation engineering—electrical and otherwise—safety measures. I must not forget to mention that the captain, when making rounds, does not neglect the kitchens—galleys they are called on shipboard—nor the storerooms, etc. Heaven help the neglectful one if any disorder or dirt are found! I love to go through our galley, and, indeed, frequently do so as a short cut to Tourist and Third Class, as it is really a joy to any woman who understands food and its preparation. The day before we are due back in the home port a safety meeting is held on board, attended by the captain and his executive officers, during which accidents, if any, are discussed, going into the cause, and asking such questions as: Could it have been avoided? How prevent a recurrence?

So much then for the prevention of accidents and disease that might be caused by faulty or unclean surroundings. What about prevention of disease, medically speaking? The first thing that comes to mind in this connection is —There goes the fire alarm! I am counting the strokes as I write . . . .

Later—I am back from the drill I mentioned before. Fact is, I am writing this while we are at our dock in Hamburg, from which port we sail later today. It—the drill I mean—is just over and everyone is going back to whatever he or she was doing before the bells rang out. To resume then: Serums is the word I was just going to write when the interruption came. Serums—of which we have an ample supply on hand every voyage, taking care that those, the time limit of which has lapsed, are exchanged for a fresh supply before sailing from New York on each voyage. We carry toxins, antitoxin, diphtherin, antityphoid, erysipelas, smallpox virus, insulin, etc.

Passengers traveling to the East and Near East usually come to us for inoculations against typhoid and smallpox. Sometimes these treatments have been started by their private physicians before sailing with not enough time to finish. In such cases the physician usually supplies the patients with serum for completion of the course. If not, we use our own supply. Again, some passengers wait until they are on board ship to begin the precautionary measures; if so, we give the first and second dosage, the third usually is given in England or France.

Emigrants coming from certain parts of Europe and the East are examined by public health doctors at the Port of Embarkation. If any communicable disease is present they must undergo treatment before sailing; if in a convalescent condition and the contagious or infectious stage has abated, they are accepted, but the case is reported to us (Medical Department) and the surgeon keeps a watchful eye on it until Quarantine is reached, then the case is reported to the health officials when they board the ship. Should vermin be found on a prospective emigrant, the condition is controlled at once. The law

requires that emigrating aliens be free from vermin before entering the United States. With the enlightened National and International Health Laws and the splendid, whole-hearted coöperation on the part of both port and ship's doctors, we have little or no trouble in checking and stopping the spread of disease among travelers in the civilized part of the world. Those who travel off the beaten track, always take with them ample supplies of serums and medications to guard against and treat disease.

It may be of interest if I tell you that men who have chosen navigation as their life's work have to study and are examined in first aid. It is quite a comprehensive course insofar as first aid is concerned. This is quite necessary because there are many ships on the sea with no doctor aboard. It is true that no passenger boats are without doctors but there are many freighters the crews of which must depend on their captain when ill.

Wireless also takes a hand in the prevention and correction of disease at sea, as this department has received wireless messages from a doctorless ship with a sick or injured sailor aboard and has been asked for guidance in treating the sick man, being told his symptoms, length of time he has been ill, etc. On receipt of the wireless our chief surgeon has sent replies outlining medication and treatment indicated.

Should a case of measles or other communicable disease break out on board, the patient is isolated at once, occupants, if any, of the room used are quarantined and the room fumigated. On arriving at our destination if the patient is still in our hospital, Quarantine takes him off our hands or arranges to send him to Willard Parker Hospital for instance. As soon as the ward is vacant, it is fumigated, formaldehyde candles being the medium.

Passengers are under no expense for either medical care or medications, if illness occurs on board ship. However, a nominal fee is charged if illness occurs prior to embarkation.

HEALTH OF THE CREW

Employee health measures are a very necessary precaution for many reasons. Not only new employees pass a rigid examination before being accepted, but every member of the crew is examined by the surgeons every voyage. These examinations are held in the crew dispensary a day or so before the end of the voyage so that, when we arrive at Quarantine, we can report any communicable disease (if any is present) to the health official. The entire crew sign off—that is, are released from the employ at the end of each voyage, signing on again a day or so before the ship sails for the next crossing—always provided each individual has a card showing he or she has passed the examination previously referred to. The card must bear the date of examination and must be initialed by the examining surgeon. If the doctor finds any defect in vision, teeth, chest, ears, throat, feet, etc., the person is given a permit for further treatment at the Marine Hospital. When the condition has been corrected, he reports back to our surgeon.

These precautions taken and no cabin or tourist passenger on our medical list, there is nothing to worry about when we arrive off Quarantine. The health officials check our reports and, finding everyone in good health, give the ship a "clean bill of health" and we thereupon proceed to our dock.

Before closing, I should mention the ship's hospital. It is on "C" deck, can be shut off from all other parts of the ship, has twelve beds in all: a ward of two beds for women passengers, same for men passengers, two beds in an isolation ward and six for the crew. All wards have their own bathrooms, a great boon for nursing purposes. There is an operating room efficiently and modernly equipped. (We do all our sterilizing on board.) There is also a dispensary for the crew. On "B" deck there is a dispensary, with waiting room and chief surgeon's office, which has been provided for the use of cabin and tourist passengers. These, plus instruments and a full line of medications, enable us to administer the "ounce of prevention" and, if necessary, the "pound of cure" as well.

Unmarried Parents

Nurses and Social Workers Discuss a Common Problem

By MARY MIDDLETON ROGERS

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"WHAT is the responsibility of the public health nurse when the family of an unmarried pregnant girl will not allow her to go out of doors 'for fear the neighbors will know'?"

This was one of the questions submitted by public health nurses in Pittsburgh to a committee of social workers which was organized by the Public Charities Association of Pennsylvania in connection with Pennsylvania's Ten-Year Program for Child Welfare. These social workers wished to know the viewpoint of members of other professions who have first-hand experience with the problems of unmarried parents. Miss Helen V. Stevens, Executive Director of the Public Health Nursing Association of Pittsburgh, is a member of the committee and was interested in obtaining from nurses on her staff questions which pertained to the relationship between nurses and social workers and which dealt with the unmarried mother as the nurse saw her.

Miss Stevens collected a number of questions from the nurses and sent these to the committee. Three members of the committee then met with the supervisors of the Public Health Nursing Association. Three or four questions were chosen which seemed typical of some of the problems uppermost in the minds of the nurses and the three members of the committee undertook to discuss these questions. The whole discussion was predicated on the assumption that the unmarried parent under discussion was mentally normal, was sixteen years of age or older and was not presenting a protective problem in the sense of wilful abuse or neglect. Later the public health nursing supervisors invited individual members of the committee to attend staff meetings at their district offices to discuss with the nurses questions which were submitted before the meeting. Both nurses and social workers found the questions and the discussions most stimulating, and they discovered how difficult it is to give categorical answers to seemingly simple questions.

The questions fell roughly into four divisions, those dealing (1) with the relationship between the nurse, the doctor, and the social worker; (2) the circumstances under which the separation of the mother and child is advisable and the emotional effect on the mother (and later on the child) of separation or of remaining together; (3) the possible alternatives that face the girl; and finally (4) the question of the father's responsibility.

THE NURSE, THE DOCTOR AND THE SOCIAL WORKER

The questions regarding the relationship of the nurse and the social worker to the client and to the physician brought out numerous questions. To quote some of these:

Should the nurse ask the family if they want a social worker sent in? Who should decide whether a social agency should be called? If an unmarried mother is under the medical supervision of a family physician, should he be consulted or not before discussing the matter with a social agency? Can his opinion be disregarded by a nurse? Can we refer the case without his consent? What right has a nurse to call in a social worker to visit a family which does not want her?

The discussions brought out the need for the nurse to interpret the rôle of the social case worker to the physician and to the patient. There was a feeling that

the idea of "a social worker" as such was perhaps formidable, but the introduction of "Miss Brown, a friend of mine, who is a social worker and who will talk to you about plans" might produce quite a different emotional reaction.

The point was made and accepted by the group that the physician and the nurse were more apt to be swayed by the immediate situation, by the panic of the parents, by the desire that "something be done" in this intolerable situation while the social worker was more accustomed to seeing the problem in perspective. Her job is to carry on either with the mother or the child or both for months or even years, long after the need has been met, and she often sees the effect of hasty action tragically working itself out in later life.

There are instances of medical or physical neglect or abuse or cases of very young girls where a protective agency would have to be called into the situation though the family may not desire or may even be antagonistic toward interference with their anti-social behavior. In the more usual case where the illegitimacy is a behavior symptom the social worker is unable to be of real service unless there is an acknowledged desire for her help. The change in the rôle of the social worker was reviewed briefly from the days when a rigid investigation of "fallen girls" was made in an authoritative and moralistic fashion to the present time when the social worker attempts without blame or criticism to enable the girl to face her problem and to work out a solution which for her and for her child seems to be at that time the best possible solution.*

Though we accept or think we accept the members of another profession, we are in the last analysis dependent on our sense of confidence in the individual, on our belief in his tact, his judgment, his effectiveness in dealing with our clients with whom we unconsciously have such a fellow feeling that we demand for them the services not of a doctor, a nurse, or a social worker but of a particular doctor, nurse, or social worker who will see this situation as we see it.

SHOULD THE MOTHER AND CHILD BE SEPARATED?

The second group of questions was concerned with the separation of a mother and child.

If this girl mother insists on having her child placed away from her own home when are arrangements for placement made, before or after the lying-in period? Who is responsible for plans and decisions for mother and baby? Should a girl give up her baby to save the family from neighborhood disgrace and to let her go on with her education or her career? Other questions showed that the nurses were aware of the possibility of later emotional conflicts in the mother or the child. Is there not frequently conflict later in life when a mother has given her child for adoption? Who should handle the problem of the girl and her baby in years to come—the family, an institution, or an agency? (Interestingly, the mother is not suggested as the person to handle the problem.) When should the illegitimate child be told that his parents were not married? Given a case where an unmarried girl and her baby have been accepted by her family, how does the social worker teach the mother to help her child meet the questions of his playmates regarding his lack of a father in the home?

The group found that they were unable to give categorical answers to these questions. They felt that no action with regard to separation should be taken precipitately. If the girl's family demand her instant removal from the home, a maternity home can be used where time is given for regaining mental and physical health and a clearer evaluation may be made by the mother of the experience she has been through. She can be with her child and can weigh the strength of her home and family ties against the claim of her helpless baby for whom she may feel unexpected tenderness and affection. She may be so

*See *The Family*, January, 1934, p. 310, "Changing Emphasis in Case Work with Unmarried Mothers." Mary Frances Smith.

dependent upon her mother or her father or upon the family as a whole that no other strong emotional tie is possible. Separation from her child may be the only solution for this particular girl at this stage in her development, but separation should come only after there has been an attempt to understand the meaning the experience has had for her, and, through her ability to face the realities of the situation, a gradual development of sympathetic understanding on the part of her family. She must be helped to weigh the decision she is making and the possible effect this decision will have not only on her life but on that of the child. Instances were cited of violent rejection of the girl by her parents and of later acceptance of her through interest in the child, after the effects of the shock caused by the breaking of the accepted code of conduct have worn off. The association with other girls who are going through an experience similar to hers and the quiet and peace of a well-managed maternity home are often beneficial for the girl and her withdrawal allows her family to adjust emotionally to the situation. There was no detailed discussion of the advantages and disadvantages of maternity homes but their availability as a temporary home for the girl was pointed out.

THE CHILD'S REACTIONS

There have been few studies made, apart from fiction, of the child and his reaction to illegitimacy.* We know something about the adopted child,** who is the child separated from his own family, but the illegitimate child's feelings and thoughts about his situation have not been studied. Probably most adopted children think they are illegitimate when they are old enough to understand concepts of legality and of social codes. The child's first understanding is only of difference from his playmates if he does not have a father and a mother. The child of divorced parents is subjected to much the same emotional stress.*** Edith Wharton's novel, "The Children," portrays most effectively the plight of the children of divorced parents. A child who is secure in his place in a family, whether it be his own or another family, who knows that his questions will be answered and that any matter may be discussed with frankness and truthfulness is apt to grow up accepting the values which those around him hold. This child is not tormented with a sense of mystery and of a longing for facts which are denied nor is he shocked at adolescence with a sudden revelation that he does not "belong."

To return to the unmarried mother, social workers could give instances of positive emotional trauma through sudden and ill-advised separation which even a later happy marriage and the birth of other children could not cure. They also knew of other situations where mothers had kept their children through a sense of duty or of guilt and far greater wrong to the child came from the mother's lack of love than probably would have come through early separation. How any given person will react to a situation can only be surmised when we have a careful study of the background and personality of the person. To quote J. Prentice Murphy, "Case work implies an understanding and appreciation of the mysterious forces which concentrate and make up the life

*Among the classic novels dealing with the illegitimate child are Victor Hugo's "Les Miserables," George Eliot's "Silas Marner" and "Adam Bede," Dickens' "Oliver Twist" and "Bleak House," Thackeray's "Henry Esmond."

There are also the more recent novels, Rebecca West's "The Judge," Thames Williamson's "Woods Colt," Peterkin's "Scarlet Sister Mary," Galsworthy's "Beyond," "Saints' Progress," and "Justice," Hervey Allen's "Anthony Adverse"—the child of an adulterous union rather than the child of an unmarried mother. There is also Benet's study of Melora in the narrative poem "John Brown's Body."

Hawthorne's "Scarlet Letter" is more concerned with the unmarried mother, as is Edith Wharton's "The Old Maid" and Hardy's "Tess of the D'Urbervilles." His "Jude the Obscure" deals with unmarried parents.

**"The Life of the Adopted Child"—Martha Vansant, *The American Mercury*, February, 1933, p. 214.

***"The Aftermath of Divorce," anonymous, *Harpers Magazine*, August, 1934.

of every single human being—it implies the giving of opportunity to develop the things that one wants to develop; opportunity to be understood and to understand, for both go together."* If we accept this statement we realize that although the case worker can bring no ready solution for the problem confronting the girl and her family, she can offer understanding and she can by her calmness and her refusal to be driven headlong into action bring a sense of strength and of confidence to the girl who is torn by her suffering and her too close proximity to the problem.

ALTERNATIVES FACING THE GIRL

The social worker must be prepared to offer at the proper time not only interpretation but various possibilities of action so that the girl and her family will not feel that they are trapped by an intolerable situation. A few questions brought out this need for alternatives.

Where can a young girl be placed before confinement if her family throws her out? Do you consider housework as an opening for the girl who is equipped for other work? What work may a girl secure when she has recovered?

No two situations are the same. A boarding foster home or an institution for the child where the mother may visit until she has tested the strength of her feelings and desires or until she has made an economic adjustment may serve in some cases. At times a foster home may be offered where the mother and child may be together and where the girl with strong maternal feelings may have her baby with her at night. Relatives who have never been helpful may unexpectedly show sympathy and understanding and may take the child temporarily or permanently. Marriage to the child's father or to another man may work out satisfactorily if there is sufficient affection and dovetailing of interests to offset the unpropitious beginning. There is the possibility that the girl's own parents may, even three or four years later, accept her and her child if the girl's determination to keep her child has carried her through this first difficult period. And finally there is early permanent separation which is sometimes necessary but much less frequently than one might think. Every worker could tell of instances which would illustrate the success or failure of each of these ways of meeting the situation. The personal equation, the preparation for life, the emotional maturity, the ability to handle her own problems are the final imponderables which lead to the mother's decision and to her fortunate or her unfortunate relationship to her problem.

THE UNMARRIED FATHER

A few of the questions are concerned with the father's part in this problem.

What is the usual attitude of a social worker toward compelling the father of an illegitimate child to contribute toward its support? How much responsibility can the father be made to assume, (a) if he is single, (b) if he is married to another woman and has children? Does the father of an illegitimate child have any right or responsibilities?

Again we must admit that we know of no studies of illegitimate fathers.** Our terminology is faulty in that the parents are "illegitimate" rather than the child. Laws dealing with illegitimacy vary from state to state. In many states the law is concerned primarily with protecting the community from the expense of supporting a child born out of wedlock; it attempts to establish the paternity of the child because such establishment will give the child the right to support from the father. The father has the responsibility of providing support for the child, usually until he is of working age, and of paying for the lying-in expenses. The legal action is usually essentially a criminal action and therefore the law is not concerned with protecting the "rights" of the guilty party beyond the right to a fair hearing.

As a matter of practice legal action is many times useless. A man who does not work or who cannot get work cannot

*"Mothers and Mothers," J. Prentice Murphy, Children's Bureau, Philadelphia.
**In fiction see Floyd Dell's "The Unmarried Father" and Allen's "Anthony Adverse."

be depended upon to pay a support order. The unmarried mother naturally dreads the ordeal and the publicity of the court procedure. If the man's income is small the judge is, in the case of a married man, faced with the dilemma of penalizing the children of the legal marriage for the child of the illegal union.

RESULTS OF DISCUSSIONS

At the end of this series of meetings the social workers felt that they had participated in a most interesting and instructive experience for them and, they hoped, one with some value for the nurses. They were quite willing to admit that they were not able to give direct answers to most of the questions asked. They felt that illegitimate parenthood was symptomatic of maladjustment whose causes could only be discerned through careful analysis and study. Case work with the unmarried mother should attempt to give security and physical and emotional adjustment to the child, should secure emotional adjustment for the mother and acceptance by the father of his responsibility to the mother and child, and in some cases there is additional need to promote adjustment on the part of the father.

These meetings focused attention upon the need for greater emphasis upon the welfare of the child and showed that a solution which met the needs of one mother might not meet those of another. Interpretation to the mother and her family should be given in such a way that the child and the mother may be guarded from the effects of hasty and ill-considered decisions made under severe emotional strain.

The professional respect of the two groups for each other was strengthened by the joint meetings.

Editorial Note: Because of limitations in space Miss Rogers' case story which was included in the article and which illustrated some of her points, had to be omitted. Anyone wishing to see the complete article may borrow it by writing PUBLIC HEALTH NURSING.

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR AUGUST 1935

Public Health in the Air Service

By CHRISTINE THOMPSON, R.N.
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AVIATION has made constant progress over a long period, but chiefly since 1925 the airplane has become increasingly important as a means of transportation. With the airplane there have arisen new public health problems with which the public health nurse should be acquainted.

Many do not realize how much flying is really being done in the United States and throughout the world. There is little if any part of the world today that has not been invaded by air travel. The United States leads the world with best equipment, service, and pilots. This country is a network of lighted airways (for night flying) and ground radio stations.

American Air Lines
A Hot Dinner is Served to a 27-Day-Old Traveller

NEW PROBLEMS IN DISEASE TRANSMISSION

Aviation has been responsible for many public health problems, many of them problems on which action has had to be immediate to avoid serious results. There are many causes for the problems that present themselves and this article will endeavor to include those that seem the most important, such as:

1. Journeys from distant infected countries are accomplished within the incubation periods of the major infectious diseases.
2. Illicit landing or forced landing of aircraft may result in the importation of infection at places other than authorized air ports equipped to deal with it.
3. Rapidity of travel may be responsible for the arrival of infected live mosquitoes in countries ordinarily unfrequented by them.
4. Aircraft while over cultivated land or water supplies may let fall refuse matter capable of conveying infection.

The diseases to be considered are chiefly plague, cholera, yellow fever, typhus and smallpox. Apparently healthy passengers arriving by air from local infected areas may import other serious diseases. Surveillance should be insisted upon until the incubation period is passed, but this would not be practical as there would be no advantage in fast travel if a person must remain in quarantine at the port of destination. However, a rigid examination could be made of embarking passengers from known infected areas to be sure all were free from manifest symptoms. Likewise, the aircraft prior to departure should undergo a thorough cleaning and disinfection. Transmission of disease through rats is very limited as there is very little chance of rats being transported by air.

The problem of illicit or forced landings is chiefly confined to privately owned craft on non-stop flights from one country to another or flights as the recent Australian Air Derby. This problem might be solved by a law requiring persons to notify the customs office when and where they landed and to report to an inspector. Illicit landings necessary in smuggling aliens or illegal drugs into the country can be suppressed by due application of the law.

Several experiments have been performed by the U. S. Public Health Service with regard to the transportation of insects. One of the diseases over which the U. S. Public Health Service has shown much concern is yellow fever, a disease which at present exists in only two parts of the world, the northern part of South America and in West Africa. For the transmission of yellow fever the Aedes Aegypti mosquito is necessary. This mosquito occurs in many countries such as the United States and India where yellow fever does not exist. After biting a patient with yellow fever the mosquito does not become infective for about twelve days, but it then remains infectious for a considerable period and perhaps for life. The admission of an infected human by air or otherwise would be a matter of no consequences unless the Aedes Aegypti were present. Neither in fact would the admission of infected Aedes Aegypti be a matter of great importance if conditions for breeding were not favorable. Of tremendous importance, however, is the possibility of introducing bitten infected humans or infected Aedes into countries where this mosquito normally exists, which is the case both in the United States and in India. The former is exposed to risk from South America and the latter, with the development of new aerial trade routes, to Africa. The airplane brings Miami, Florida, the gateway to Central and South America, within less than a day from certain ports known to be infected. When passengers take to the air, mosquitoes come as stowaways in baggage, clothing, and dark compartments of the plane.

The French Government made several investigations and decided that the danger of airplane transmission of this disease was not likely as mosquitoes cannot live in high altitudes. Fortunately, our United States Public Health Service did not dismiss the problem so easily and was not satisfied with this conclusion. Airplanes coming from infected areas were examined thoroughly and small power suction apparatus used to hunt the specially stained mosquitoes. They were found to be present and alive.

After this enlightening experience no more chances were taken. Special care is taken at all ports of call not to allow mosquitoes to enter, all refueling and taking on passengers come under rigid inspection, and every plane is cleaned by suction at each port of call and at every over-night stop the plane must be disinfected. Also, every person coming by plane from Central and South American ports must pass special examinations given by the United States Public Health Service. Any person showing questionable symptoms must go into quarantine until the danger is past. The Federal Government has a Quarantine Hospital on an island near Miami for this purpose.

The chance of spreading infectious diseases by careless handling of sewage from planes is at a minimum in this country as small septic cans are used and interchanged at ports. However, if sewage were dropped in the water supply of a city or places capable of spreading disease this method would not be free from health risks. Although there is little chance of such carelessness being practiced, health authorities should be on the alert to see that it does not occur.

The problems associated with food supply and water are practically the same as found in all restaurants, hotels, or trains, and great care is taken by airlines to provide good food and water under best sanitary conditions possible.

MORTALITY RATES IN AVIATION

There is a tendency on the part of many people to feel that air travel is much more dangerous than other means of transportation. Of course, the daily newspapers usually make a sensational story of an airplane disaster and little is said of a train wreck or of the thousands of people killed yearly in automobile accidents. Naturally deaths from airplane accidents in the past seven years have climbed. The number of deaths from airplanes over the period from 1919 to 1927 averaged about 156 deaths per year or .2 per 100,000; then in 1928 the death rate doubled showing 473 deaths or .4 per 100,000, and has con-

tinued about the same each year since that time. Age distribution is practically limited to two age groups, 20-29 years which is highest and next 30-39 years. This grouping would seem logical as this age group would take in all pilots and the most common age group of passengers.

The sharp rise of yearly fatalities has not yet been completely explained. However, the general opinion is that the airplane has gone through the same stages as the automobile. When vital statistics first took notice of auto deaths in 1906, only 183 fatalities occurred in the United States registration area. Immediately, however, a sharp rise was observed. The mortality rate doubled in two years and tripled in three years, and in ten years was fifteen times as high as the first year. Passenger miles flown per passenger fatality for 1930 were 4,322,902; for 1931 the number was 4,770,876.

Insurance companies have taken keen interest in aviation and at present 60 companies will write policies for pilots and student pilots; 84 companies will write policies for passengers and pilots.

SAFETY AND SERVICE OF AIR LINES

The pilots give and receive weather reports every thirty minutes while in the air and the ground radio stations know every minute the location of all planes. The radio beam guides the pilot especially when flying blind. The radio beam is a code of dots and dashes, and by this code the pilot knows if he is on his course, as the code changes when he is off it. Lighted airways with beacons about every fifty miles and frequent emergency landing fields add to the safety of flying in case a plane is forced down. The planes are tested thoroughly to be sure they are airworthy under most adverse conditions.

Heating and ventilation of passenger planes is next to perfect. In winter, the cabins are safely heated by latest methods, and in summer, even though it is hot on the ground, planes are cool and free from dust and dirt. Air can be changed every three minutes.

Flying is more than an ordinary activity from a medical standpoint and calls for a physical and neurologic make-up in a pilot that is more exacting than the requirements in other pursuits of life. The periodic medical examination aims to aid in the selection of those showing the maximum in way of suitability, and what is more important, it aims to maintain this suitability. In the past fifteen years the medical profession has devoted much time to devising tests to determine the suitability of fliers. Many of the tests used today had their origin in observations made during the World War.

Special attention is given to examination of eyes as a flier must have good eyes. A flier must have the ability to judge distance and good field of vision as to form and color is essential. Ears are examined for defects. Another test is given to determine defect, if any, in equilibrium. A flier is also tested as to what his reaction would be in time of stress.

The Department of Commerce accepts or rejects its applicants on the basis of its set of physical standards. About seven hundred and fifty physicians are licensed by the Department of Commerce to give examinations. The Department of Commerce and the air lines feel that the public is entitled to safety in the air and require their pilots as well as their planes to be airworthy.

ILLNESSES PECULIAR TO AIR TRAVEL

Thousands of people, healthy and otherwise, avail themselves of modern facilities such as mountain railways and airplanes and ascend to great heights. From a medical viewpoint it is not only the altitude itself which is of importance, but also whether we are in action or passive, or whether we reach the zone of reduced air pressure slowly or rapidly. Flying places man under the same biological conditions as a bird. It demands rapid and enormous variations in altitudes and orientation in the three dimensional movements. The injurious factors are physical influences: alteration in air pressure, diminution of oxygen and in addition to this more or less strain on somatic energy. Special demands are made on the mental and

psychic capabilities. Symptoms of air sickness are dizziness, nausea, vomiting, pressure in the head, whistling and hum in the ears, diminished hearing, weakness, and various disorders in the intestinal tract. Fear seems to play a big part in air sickness. There is little record of illness of airpilots and today air sickness is rare among passengers. The Department of Commerce and the various air lines feel that the flight surgeon must be a physician who takes frequent trips by air to be able to understand all the problems of illnesses brought about during flight and caused by flying. Some flight surgeons have found that pilots who have been flying a long time appear to have diminished hearing perhaps due to the constant noise, but with comparatively noiseless engines there is less likelihood of this. Also the radio beam which causes constant noise in the ears of the pilot tends to produce what is known as "static ears". Radio beam is especially disturbing during electric storms.

THE NURSE IN AVIATION

The nurse can be of great importance and service to aviation. Nurses are going to be needed at airports, in airplane factories, as assistants to flight surgeons and examiners, and many air lines are already aware there can be no better hostess than the trained nurse. Airplane ambulance service has not yet developed in this country, but its use will become more prevalent, and a nurse to accompany the patient by air is desirable. With the possible use of air ambulances in the next war, the nurse will again have a big part to play. How much more valuable and useful she will be in any of these fields if she knows the rudiments of aviation, the health problems of the air, and is familiar with flying!

SERVICE IN AIR AMBULANCES

The value of the air ambulance today is no longer in doubt. The Swedish Red Cross has the honor of having taken the initiative of establishing the permanent Civil Air Ambulance service but was soon followed by many other countries, France, Finland, Greece, Siam and Australia. One of the earliest pioneers in this work was Mlle. Marie Marvingt, a nurse who had obtained a pilot's license back in the days when women rarely attempted such an undertaking and aviation was just developing. At the second Congress on Air Ambulance in Madrid in 1933, she insisted on the importance of the nurse in a well organized Air Ambulance service and brought forward a resolution urging that facilities be accorded nurses to train for this service. Training and preparation for this service consists of selecting nurses well trained and instructed as to general principles of aviation, and of testing these nurses as to their "airworthiness." There is a wide difference of opinion as to just what extent the nurse should be trained, but it only seems reasonable to have first of all a well trained nurse, then test her as to ability to adjust to air travel. She must be capable to carry on all duties expected of a nurse and to do it in a calm and efficient manner. Much will depend upon personality and temperament, as panic in the air is catching. There is always the possibility of a forced landing through weather or other conditions which would call for a maximum of resourcefulness and many allied qualifications in the nurse who is in charge of a patient being transported by air. Air ambulances can be of great service in vast and sparsely populated countries and to countries not easily contacted by means of road or train travel where medical centers are far apart and the patient needs attention quickly to save his life. In this country it is possible to contact many points in Alaska, winter and summer, which would be impossible were it not for the use of the airplane. When the rivers or ocean cannot be traveled to reach points a plane goes into these regions with mail and supplies and on many occasions medical care has been made possible to the patient in these areas. The Third International Air Ambulance Congress was held in Brussels in June 1935. This Congress was organized by Royal Aero Club of Belgium in conjunction with the international Aeronautical Federation

and the League of Red Cross Societies as a concomitant of the Brussels Universal Exhibition. It is under the patronage of Her Majesty the Queen of the Belgians. It will be very interesting to see the developments that have been made and the recommendations for the future in this service that will follow when reports of this Congress are available.

At the present time nurses have scarcely invaded this new field except as air hostesses or stewardesses as they are sometimes called. The air stewardess must meet many qualifications to be eligible for this position. She must not weigh more than 118 pounds. She must be between 21 and 27 years of age. She must be attractive and neat, and with an adaptable yet stable personality.

The uniform worn by the stewardess is a strictly tailored suit, tailored blouse with tie and over-seas hat.

Her duties are many. She has the full responsibility of the passengers and their belongings. It is her duty to see that their journey is pleasant and comfortable and not just a boresome trip. In case of illness or accident she gives emergency care. She must know the country along the route well enough to answer any questions that might be asked in regard to it. She serves attractive luncheons to the passengers while aloft, and performs a multitude of duties that make flying a real comfort and pleasure.

The nurse has proved her worth to the air lines on many occasions, for example last winter when a plane was forced down in the mountains during a snow storm, was wrecked and the pilots were injured, as well as several of the passengers. The nurse herself escaped injury. She gave first aid to all the injured, then walked several miles through snow and mountainous country to summon aid, and directed rescuers to the scene of the crash. If this nurse had not been the well-trained person that she was, serious results might have occurred. When she was praised very highly for her splendid work, she replied by saying, "It was only my duty." This is only one of the many instances where the nurse has proved the value of her services.

Many people have the idea that an air hostess must be the adventuresome type of person. On the contrary, she is a very serious minded person and goes about her work in a professional manner. She is actually in the air about 18 to 20 hours per week or around a thousand hours per year. She must have two homes, one on each end of the route. There are approximately 150 nurses in the service and about 5,000 on the waiting list for positions.

The public health problems in aviation are only beginning. With transoceanic travel in the near future, new international regulations will have to be considered, such as large customs and quarantine stations to prevent transmission of infectious diseases and the smuggling of goods into the various countries.

The future of the nurse in aviation, it is evident, will be one of constant progress and development. The nurse will not be left behind but will take her rightful place with other professions connected with this great field of aeronautics.

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Nursing in the Automotive Industry

By WALLACE G. PICKERING, R.N.

THE author is one of the corps of six registered men nurses of the medical department of one of America's major automobile assembly plants employing four thousand men daily. Directed by a resident surgeon, we minister to an average of three thousand accident, industrial and non-industrial disease victims a month. Because of the many other strictly nursing duties performed here, the doctor combed the field of registered male nurses to organize his efficient staff. The equipment of each consists of psychiatric and general training, institutional and private duty experience and commercial education. Even if there should be but one nurse available at a time, our surgeon has in him a chauffeur, an investigator and a secretary.

PRELIMINARY EMPLOYEE EXAMINATION

We are as much concerned with the prevention of accidents as we are with caring for the injured and sick. With the advent of the rush season, the various foremen saunter out to the gate and select from the hordes of job seekers an average of seventy applicants daily, many of whom are former employees. Regardless of the position he seeks, every applicant, except those who have not been out of our employ for more than two months, must submit to a complete physical examination before he is accepted by the employment bureau. One nurse seated outside the dressing room inspects the credentials provided each applicant by the placement officer; a second nurse examines his eyes, a third performs a complete urinalysis, a fourth conducts him into a dressing booth, instructs him to strip down to bare feet, weighs and measures and escorts him into the physician's office. Here he is examined for circulatory, heart, lung, gastro-intestinal, nervous and mental diseases, abnormalities and deformities. Even if the physician discovers the applicant is physically or mentally unqualified for employment, his record is preserved permanently just as if he had passed with a one hundred per cent rating.

While this examination seems costly, in reality it is a great economy, benefiting the employer, employee and the insurance company. It prevents the incompetents from being assigned jobs and eventually endangering the lives of others and directly affecting production. It prevents the chiselers from collecting on false claims of having suffered the loss of an eye, a finger, an arm, contracting a hernia or other injury while employed here. It also makes it possible for the handicapped to earn a livelihood, since the doctor advises the placement officer to assign such a worker to a job suited to his capacity.

Once the applicant has passed the physical examination, it is our duty to make certain that he understands the "Safety Advice" card which contains advice and rules on preventing accidents. Despite the safety devices throughout the plant, our lectures, the presence of the insurance company's safety engineering inspector and the placarding of safety warnings from one end of the plant to the other, accidents prevail everywhere but in our own department and in the main office. From the unloading of car parts in freight to the final inspection of the completed automobile, each operation in assembling a car has its peculiar hazards, inflicting characteristic injuries or industrial diseases.

SEEKING FIRST AID

Each employee seeking first aid must bear a supervisor's accident report. This document, signed by the foreman and never destroyed, is our heavy artillery in our constant fight to prevent accidents. It tells where, in

what department, and when the accident occurred, the name of the injured and a description of the accident and nature of the wound, precluding any possibility of reporting injuries suffered outside of employment. It describes what unsafe act was committed, why it was committed, what unsafe condition existed, and what should be done to prevent similar accidents. When you find the injured man to blame, you lecture him on the value of practising safety measures, and similarly if a coworker caused the accident. Where defective machinery or factory equipment is at fault, you report to the surgeon, who in turn discusses the matter with officials to prevent a repetition of the accident. Naturally, the injured man usually reads this report en route to the medical department and, if he is to blame, it has a good psychological effect on him, to the advantage of all concerned. From these reports we compile a weekly chart containing the number and percent of accidents in the individual departments and the plant as a unit. A copy of this is submitted to our surgeon, the factory service manager, the insurance company, the latter's safety engineering inspector and claim adjuster, the general manager of the factory and to the safety director in the main office; all of whom peruse the report faithfully and devise means of preventing future accidents and disease. Woe be to the foreman whose department shows an increased accident rate.

FOLLOWING UP INJURIES AND ILLNESS

We compile a complete and accurate record of every industrial injury and disease and non-industrial injury and illness. Every three days one of us invades the active file and removes the records of those who have failed to report daily for redressings or treatments. Armed with these cards, the investigator ferrets out the delinquents in their respective departments, ascertaining whether the injury requires further treatment, whether the patient has entrusted the case to his own physician, whether the patient has been discharged or quit his job. The result of each investigation is recorded on the record over the signature of the investigating nurse. Besides having a definite conclusion to each case, we thus keep infections and other complications at a minimum. Those who have neglected their injuries are warned to report regularly on the penalty of discharge. One finds various reasons for these delinquents: some claim their foreman refused them permission to visit the first aid room, some boast that they have adopted the fresh air cure, *i. e.*, exposed their wounds; ignorance and carelessness also account for many delinquents. But regardless of the cause, it is our duty to remove it if possible. We must make workers appreciate the danger of neglecting injuries, and to realize that the medical department is there for their benefit at all times. Where we find a foreman guilty of refusing an employee the privilege of reporting to the medical department, we file a complaint against him with the plant manager, and have no further trouble from this source for many months.

APPOINTMENT CARDS

In order to keep at a minimum the time lost by the injured availing themselves of the benefits of our department, we provide each with an appointment slip for redressing or subsequent treatments or for consultation with the resident and visiting surgeons. This is a recent experiment that has increased the coöperation between the foremen and injured and us. Foremen naturally are suspicious of men requesting the privilege of visiting our department; they believe they use this as a ruse for sneaking up to the locker rooms for a sandwich. Thus when an injured man shows him the appointment slip the foreman is convinced that his request is legitimate, and will provide him with a relief worker. Without the latter, one man leaving his specific operation would hold up the entire production line, for each has a certain job to perform in the making of an automobile.

Wherever possible, the injured are always kept on the payroll. Naturally, a solderer with a broken arm encased in plaster is not capable of performing his regular operation and his foreman is in-

structed to provide him with some other duty, such as sorting bolts or screws or running errands. Occasionally circumstances prevent the execution of this order and the man returns to work without permission. Violation of the rule subjects the injured to prolonged and costlier recovery or may result in permanent disability, or may endanger the lives of others, retard production, create imperfect workmanship, injure the reputation of the department or eventually force the patient on a furlough without pay or discharge from the payroll and entrance on the compensation list. Violators of our order are therefore threatened with discharge.

COMMON DIFFICULTIES

Infections are few, averaging about three daily. These usually can be traced to the carelessness or ignorance of the injured. It is physically impossible for us to give each of these cases, averaging 150 for the day shift and 90 for the night shift, two dressings daily or one at end of the day's work. Thus, with their dressings laden with dirt and grease, they remove them when washing up to go home and leave their wounds exposed until the following day or take a chance at dressing them themselves at home. Incidentally, when you instruct a patient either to soak or keep wet a dressing at home, you must make certain that he understands that he is not to add even salt to the water, otherwise he will soak his injury in strong solutions of lysol or other disinfectant and produce serious harm. And the minute you remove the old dressing and turn your back to deposit it in the soiled dressing receptacle, the patient will prod the injury with one of his dirty digits and run the risk of introducing infection. It is a hazard we must warn patients against continually.

We are only permitted to administer to the ill medicines or drugs for *temporary* relief advising the patient to consult his own physician for further treatment and advice. Those stricken with acute abdominal pains or other serious illness are despatched in our own car, one of us driving, to the hospital or home. None is permitted to leave work on account of illness without first submitting to an examination and being supplied with a written approval of his claim. Nor is anyone permitted to return to work after recovering from an illness until we examine and supply him with a medical "o.k." In order to absolve the company from blame in these cases, we compile a complete record for each one, for regardless of how insignificant either an industrial or non-industrial case may seem, there is always the possibility of it eventually reaching the workmen's compensation commission. Thus we accord these reports of outside illness or injury as much consideration as we do our other duties, avoiding all short cuts and lack of clarity. Careless reporting can result in a waste of time, and our surgeon and other officials and the insurance company's agents often have occasion to consult these records.

CLEAR DISTINCTION BETWEEN NURSING AND MEDICAL DUTIES

Regardless of the emergency, we perform no suturing, incising or other surgery. This is the duty of our surgeon, and in his absence we despatch those requiring it to the hospital. Lacerations and abrasions are the most numerous injuries. We use Dakin's solution for removing clotted blood, ether or amyl acetate (paint thinner) for scrubbing off the grime and grease, and either iodine, mercurochrome or S. T. 37 as a sterilizer. The first dressing of all of these wounds is of Dakin's solution to prevent infection. When indicated, we use for subsequent dressings a compound of vaseline, zinc oxide and ammoniated mercury ointment. Because ointments have a tendency to produce eczema, we use them sparingly. We use coaptation splints whenever the moving of a joint is bound to retard healing.

SPECIAL SERVICES

We do all within our power to return the injured and sick to normal. Those who are confined to their homes with industrial injuries or illness are visited by our surgeon daily, and we never hesitate to despatch to a hospital those seriously injured or those requiring surgery (both

of which are treated by the insurance company's staff of specialists). Our surgeon is on duty from eight a. m. to four-thirty p. m. daily, reserving the time from three p. m. to four-thirty p. m. for the benefit of the night shift coming to work at three. Mondays and Thursdays the insurance company's general surgeon, neurological and orthopedic surgeons and ophthalmologist conduct, with our own physician, clinics from two p. m. to four p. m., making it possible for the injured of both shifts to avail themselves of their services.

GENERAL EQUIPMENT

Though limited and compact, our equipment and quarters are surprisingly efficient. We make and sterilize our own dressings and compound most of the ointments and solutions utilized on the premises. There is a private office for the surgeon adjoining our improvised operating room. We have two cots, a water sterilizer, two instrument sterilizers (one of which we use exclusively for boiling urine specimens, a dozen at a time) and medicine, instrument and dressings closets crammed with supplies, and there is one huge room in which we perform most of the dressings, treatments, examinations and clerical work.

VARIOUS TYPES OF INJURIES

Puncture wounds, imbedded steel and wooden splinters and contusions rank next in number. Where possible, all puncture wounds are soaked in hot water, cleansed with ether (this always leaves a dry surface) and cauterized with carbolic 2% and done up in huge wet Dakin's dressings.

The victims of extensive wounds are given antitetanus and gas bacillus vaccine.

Unless a sliver may be removed easily, we do not dig into the wound with an instrument. We continue hot soaks in plain water applying wet dressings and, if it does not emerge within twenty-four hours, our surgeon extracts it surgically.

All severe contusions are subjected to X-ray, with the result that we frequently find longitudinal fractures, to which the surgeons administer. Ordinary contusions are treated by hot soaks, snug bandages (never adhesive strapping because of the dangers that might result from increased congestion) and the injured member is put at rest in a sling or on a crutch.

Compelled to perform their specific operations within the cramped quarters of car bodies, the upholsterers suffer strained backs, sprained ankles and tenosynovitis of hands, wrists, forearms, fingers and feet. Tenosynovitis of the hand and forearm is treated with hot soaks and they are immobilized in splints fashioned to fit out of plaster of Paris bandages. We wall off with sheet wadding each finger or toe when wrapping two or more together either in splints or splintless dressings, so as not to produce an eczema.

Many of the body builders are subject to acid, solder, friction and acetylene torch burns. Those suffering acid burns of the eye become aware of the injury immediately and rush to the medical department. Here we flush out the eye with alkaline eye wash, remove with a sterile swab, solder or whatever foreign body may be present, apply cold compresses and either holocain and epinephrine 1% to relieve pain or mercurifom 1:3000 to prevent infection. Treated thus, these cases rarely ever become serious.

But this is not true of acid burns on other parts of the body, for the victims pay little attention to the sting or itching first noticed. Consequently we do not get these cases promptly and the burned area becomes gangrenous, black, punched out areas ranging from the size of peas to twenty-five cent pieces on arms, hands, legs and feet. These we soak in hot water for one hour and then dress with soda bicarbonate, warning the patient to keep the dressing wet at all times. These wet dressings are discontinued as soon as all slough or pus disappears and are replaced with a compound of vaseline, zinc oxide and ammoniated mercury ointment. Occasionally it is necessary to remove with forceps the gangrenous cap on these wounds. Our surgeon occasionally finds it neces-

sary to aid recovery of these injuries with skin grafting.

All friction, solder and torch burns receive picricain ointment dressings at the time of injury to relieve the pain. This also is packed into the deep, bullet-like wounds caused by red hot welding rods. Subsequent dressings are of the ammoniated ointment compound. One must exercise perfect asepsis with these cases at all times to prevent infection, using sterile goods and instruments and medications only.

Because of the grime, grease and friction produced by contact with metal, all employees are subject to attacks of furuncles. These patients we subject to sunlight lamp treatments daily, dress their boils with either ergophene or ichthyol, supply them with I. Q. & S. and advise them to eat at least three oranges daily and force fluids.

Lead poisoning, which is contracted through inhalation and digestion, is confined to the men engaged in buffing the solder applied to unions on the car bodies. These men perform their operation within an enclosure to prevent the fine solder dust from spreading over the factory and endangering the health of others, and each solder buffer is provided with a respirator. Monthly each body builder is summoned to the medical department and thoroughly examined for symptoms of lead poisoning or other diseases, and a record is kept on file. Whenever one shows the least sign of absorbing lead, or symptoms of other diseases, he is ordered a change of occupation and prescribed treatment accordingly. Whenever we contact the solder buffers we warn them about the necessity for washing their hands thoroughly before eating and to eat beyond the confines of their department. (Incidentally, for the general welfare of the plant, all the shifts are alternated weekly, and the men are urged to spend as much time in the open as possible.)

Regardless of the reason for visiting the medical department, even if it is just to get a few aspirin tablets to relieve a headache, the worker's number is reported on a daily medical chart, and a careful record kept in this way of his general condition.

THE SOCIAL SECURITY BILL

As we go to press the Social Security Bill awaits the President's signature to become enacted. The principal provisions of the Bill as it now stands are as follows:

Old Age Security. Provides state aid and Federal benefits for the aged and dependent.

Unemployment Compensation. Aims to prevent a repetition of the present unemployment crisis through state aid for unemployment compensation plans and a Federal tax on employers.

Dependent Children. Aims to stimulate better and more adequate mothers' pensions.

Maternal and Child Welfare. Provides $3,800,000 for maternal and child health services; $2,850,000 for crippled children; $1,500,000 for child welfare; all to be administered by the U. S. Children's Bureau.

Public Health. Provides $10,000,000 to be administered by the U. S. Public Health Service, $8,000,000 of which will be assigned as grants-in-aid to the states, for establishing and maintaining adequate public health services and the training of personnel; $2,000,000 to extend the services of the U. S. Public Health Service.

While it is too soon to discuss in detail how this will affect the public health nursing field, it is probable that new impetus will be given to the extension of public health nursing service in rural areas as well as in cities, and that there will be unusual opportunities for well-qualified nurses with special preparation in public health nursing.

A Cost per Visit Study

By JULIET MARLOW, R.N.
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There is so little material available on the cost per visit in an official agency that we are particularly happy to have Miss Marlow's discussion of the study made in Syracuse.—*The Editors.*

IN the December, 1934 issue of PUBLIC HEALTH NURSING a new method was suggested to public health nursing agencies for computing the cost of a visit. An experiment was tried in applying this method to the 1934 cost and visit data of the Nursing Bureau of the Syracuse Health Department. This Bureau carries on a generalized educational service in the fields of prenatal, child hygiene, school, communicable disease and tuberculosis. The educational services are rendered in clinics, schools and home visits. Any case requiring bedside care is referred to the Visiting Nurse Association.

The personnel of the Nursing Bureau consists of a director, three generalized district supervisors, one special tuberculosis supervisor, one part-time nurse who teaches prenatal mothers' classes, twenty-five staff nurses and four clerk-stenographers. The Nursing Bureau is divided into three substations with a generalized district supervisor in charge. These substations are located one in the center of the city, City Hall Substation, one on the north side in a public school, Franklin Substation, and one on the western side, Seymour Substation. The distribution of nurses to the substations is not equal. Since nearly all the studies made previously have been made according to the substation it seemed advisable to make this experiment by substations also. In the past all the comparisons have shown a great uniformity of service despite the difference in location of substations and variation in number of nurses reporting to each.

The total budget of the Nursing Bureau in 1934 was $52,660. Rent, light and heat items for the three substations are not included in this total, and estimates were therefore made for them, and added to the total budget. The rates paid by the Visiting Nurse Association were used for the City Hall Substation. For the Seymour Center, actual figures could be obtained as rent is paid for this station by the Bureau of Child Hygiene. This same figure was used for Franklin with a slight difference in cost for telephone service. With the addition of these estimates the budget became $56,586.

In order to make a study of the cost per visit by substations it was necessary to distribute the budget according to the staff serving each one. The salaries of the director, her stenographer, the special tuberculosis supervisor and the nurse teaching the prenatal mothers' group were distributed according to the number of nurses reporting at each substation. The cost of supplies, equipment and transportation was allocated in the same manner. The rest of the budget was assigned according to actual salaries paid to those reporting at each substation. The staff nurses' salaries range from $1,320 to $1,500. Franklin had five maximum salaried nurses, City Hall four and Seymour two. These facts naturally influence the cost per visit. In the final analysis the budgets were:

City Hall, $23,946.85—A district supervisor, a stenographer and 9 full-time, 2 half-time, 1 three-quarter time staff nurses.

Franklin, $15,539.70—A district supervisor, a stenographer, 6 full-time, 1 half-time staff nurses.

Seymour, $17,099.45—A district supervisor, a clerk-stenographer, 6 full-time, 2 half-time and 1 three-quarter time nurses.

The method used in computing the cost of a visit is called the "Visit Basis

Method." Using the formula set up in this method it is necessary to estimate the possible number of visits that could be made in a year if all the nurses worked all the time in the field. In order to do this a sampling of ten percent of the daily assignment sheets was selected for each month of the year by substations. Since the staff nurses are required to report to the office once a day, assignment sheets were selected which included only such activities as office and field. Office time is devoted to the writing of records and planning for field work and so is a legitimate charge to the cost of a visit. After the sheets had been selected the visits were counted and divided by the total number of assignment sheets for the month for each month of the year. In this way the average possible number of visits per day was secured for each substation. When this computation was completed it was found that City Hall Substation, centrally located and needing more allowance for travel time than either of the other two substations, had an average possible number of visits per day of 16.5, Franklin 17 and Seymour 21.5* Table 1 shows the number of visits made in comparison with the possible number of visits if the nurses had worked full-time in the field. The estimated possible number of visits was secured by multiplying the number of days worked by the possible number of visits per day.

The following example is given for computing the cost of a visit in the City Hall Substation:

Budget = $23,946.85

Staff = 10.75 nurses

Days worked = 275

Estimated possible visits per day = 16.5

1. Possible number of visits by the 10.75 nurses per year = $10.75 \times 275 \times 16.5 = 48,778$
2. Visits made = 22,928
3. Percent cost chargeable to visits = $\frac{22928}{48778} = 47\%$
4. Percent deduction = 100% — 47% = 53%
5. Deduction 53% of 23,946.85 = $12,691.83
6. Cost chargeable to visits = $11,255.02
7. Cost of a visit = $11,255.02 ÷ 22,928 = $.491

Using this same method the cost of a visit for Franklin was found to be $0.47 and Seymour $0.40. Using the total budget and estimated possible number of visits a day, Syracuse had a cost per visit of $0.45 for a generalized educational service. This study points out the uniformity in the cost of a visit for each of our substations.

From the supervisory point of view a cost of visit analysis has a value in that it brings before the staff actual figures showing the cost of a visit and gives them an opportunity to compare their performance with that of a similar group. It also emphasizes the importance of studying the content of the visit and the need to make it of more value.

TABLE 1. ESTIMATED POSSIBLE NUMBER OF VISITS COMPARED WITH VISITS MADE.

Substation	Visits Made	Estimated Possible Visits
City Hall	22,928	48,778
Seymour	23,168	45,822
Franklin	15,421	30,388

There is a significance also in this type of study for the selection of cases to be visited. Money should be spent for visits to as large a number of the population as possible in order to bring returns in better health for the community as a whole.

*The absence of bedside nursing service naturally makes this figure higher than in the agency carrying a heavy morbidity and maternity program.—*The Editors.*

The Mental Hygiene of Pregnancy*

By ALVIDA LOWER, R.N.

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IN caring for the maternity patient, the nurse is concerned not only with the physical health of her patient, but also with the existence and operation of mental and emotional factors that may influence the patient's welfare. She does not see in her patient the functioning of mind and body as two separate entities, but she sees the total personality. She knows that Mrs. Smith, a young primipara, is not interested in prenatal care because to her the idea of motherhood is wholly objectionable, and that, because of her anxiety over financial matters, Mrs. Jones, a mother of seven, is not carrying out instructions relative to her physical care.

The problem of health would be relatively a simple matter if we were all entirely rational beings, but we know that we are not. We are governed largely by our emotions, which add complexity to the situation. These emotions determine to a large extent our behavior, and may also hinder or promote our attainment of health, happiness and efficiency.

It has been found that the psychoses that occur during the prenatal, intranatal and postnatal periods are of the same nature as those that occur during any period of life; that is, there is no particular type of mental illness associated with the maternity cycle. Pregnancy may, however, because of fears associated with it and the added responsibility it entails, be a factor that precipitates the breakdown.

However, when the amount of maladjustment is of a degree to constitute a definite mental disorder, it is not within the province of the nurse. These cases are cared for only under the supervision of those who have special training in this field, and are not within the scope of this discussion. It is some of the incipient and more hopeful maladjustments, with which the public health nurse comes in contact, that I would like to consider.

FREQUENT PROBLEMS

Perhaps the problems most frequently encountered during the prenatal period are those which grow out of the unwanted and unplanned-for pregnancy. An attitude of rejection is not always relievable or modifiable, but we approach the problem with a great deal more understanding when we do not unquestioningly assume that every mother should and does want her baby. There is no justification for such an assumption. We have expected too much of the maternal instinct, and there are any number of circumstances and conditions that make difficult or impossible the full acceptance of a pregnancy.

One of these, probably the most prevalent, is the lack of funds to meet the expense that a new baby incurs. In families where the income is marginal or below, the wish is often to postpone parenthood, rather than to avoid it. In these days of unemployment and economic depression, this is a problem to be faced and accepted rather than overlooked. The woman who shows some concern about the matter is probably a more desirable person than the woman who has no feeling of responsibility toward the expense of her confinement and no compunctions about adding to the relief burden. The point is that this reasonable concern must not give way to emotions such as worry and self-reproach.

To many women, a new baby means a restriction on all social activities. Their standards of what is socially proper may be influenced by those of their mothers or friends, who think that

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pregnancy is something to be concealed as long as possible, and when it becomes obvious the woman should confine herself to her home. Can the nurse's contact with the patient be such that her interpretation of what is socially acceptable will carry more weight than that of her mother and friends? Can she bring her to feel that her pregnancy is something of which she may justly be proud, rather than ashamed, and help her to see that it need be confining for only a very short period of time?

Marital conflict is often a factor in rejection. A young primipara whose married life has been accompanied by considerable discord feels that the baby will be an intruder who will tend to widen the rift between herself and her husband. She fears that he will be resentful and jealous of the baby because of the share of her time and affection it will usurp. Possibly this woman can be helped to a more sane conception of marriage, which will in turn make the baby more acceptable. We can say to her that a successful marriage does not confine itself within four walls and to two people; that they both need to have radii of contacts and interests other than each other.

Then there is the unexpected baby who comes along late in life to the mother who thought she had finished with child-bearing, and the baby who interrupts a professional career. These are a few of the many reasons which make pregnancy unwelcome. They are not, however, of the major importance. I have cited these instances merely to suggest that these attitudes can be somewhat modified and the rôle of the nurse to that extent. It is not the fact that the mother does not want her baby that concerns us so much, as the emotions that this feeling produces—rebellion, self-pity, a sense of guilt, self-reproach and bitterness. In dealing with reactions such as these, so much depends on the patient-nurse relationship. The nurse must be some one in whom the patient believes and in whom she can confide. She must be of the belief that the patient's reaction, whatever it is, does not merit censure or reproach. If she, in all her contacts with the patient, reflects this belief, she will do much to help her.

Many patients simply need some one to whom they can talk. Though their problem can in no way be actually changed, the very act of unloading it to some one who is understanding, is, in itself, of therapeutic value. Disclosure relieves it of some of its emotional tone and helps the patient to see it in a more detached way.

Not infrequently we meet the patient who never alludes to any difficulties but from whom we get a multitude of symptoms. Restlessness, anorexia, headaches, etc., are not always of organic origin, but they may be the patient's means of expressing an emotional problem, of which she is not consciously aware. This patient is unable to admit, even to herself, what it is that is wrong. It is useless to say to her "What is troubling you?" for she does not know, and the problem is often beyond her control.

NEED OF PSYCHIATRIC SUPERVISION

This is not a problem for the nurse to handle alone. She will need the aid of psychiatric supervision. Deep-seated emotions that express themselves in disguise are not easily interpreted and must be left to those of wider experience.

From the point of view of mental hygiene we would have the patient look upon her pregnancy as a normal physiological process and something quite apart from illness. But pregnancy is a state which naturally draws the patient's attention to herself. There is always something, physiological change, the movements of the baby, to remind her of her own body. It is quite understandable, then, that concern about herself and her baby may readily grow to absorb a great deal of her attention. For this reason the nurse is alert to opportunities to widen the scope of her interests and whenever possible to direct her thinking into channels which do not center upon herself.

FEARS, ANXIETIES, SUPERSTITIONS

The prenatal period seems to be a particularly fertile period for the de-

velopment of various fears, anxieties and superstitions. In spite of all our scientific evidence and our teaching to the contrary, the old fear of "marking" the baby is still very prevalent. It is not surprising that we find it among our foreign-born mothers and those for whom information has not been available. But there are very few patients, however intelligent, who, when pregnant, do not directly or indirectly express some doubt about the influence of maternal impressions. Perhaps the explanation given by a young primipara, who was a college graduate, speaks for many. She said that of course she knew better but "when one is pregnant it is so much easier to accept superstition and be afraid than to think and believe evidence."

In the light of our scientific knowledge, this fear seems very absurd—but it is not so to the patient. To her, it is a very real thing. Reassurance alone is of little value unless it is accompanied by a tolerant attitude and a patient, scientific explanation of the problem. This is the only rational approach to any kind of fear, whether it springs from superstition and ignorance or is reasonably founded.

Closely related to the fears of marking are those of direct hereditary transmission. Mothers fear that their babies will inherit the father's bad temper, the mother's "tendency to blues" and what not. Frequently, we hear a remark such as, "I know my baby will be a cry-baby, because I cry all the time myself." These mothers are of the mind that they themselves are wholly responsible, because of heredity, for whatever the child may be and are very much distressed. We have a pet colored patient, though, who has another philosophy about this matter. When the nurse made comment on her fine brood of healthy, intelligent children, she responded, "Well, doan' give me no credit, ma'am. It's the Lawd himself that give me dem deah kids."

Because these various doubts crop out so readily, we are eager to know the patient as early in pregnancy as possible. This early contact provides the nurse with the opportunity to inculcate attitudes that make for wholesome thinking before erroneous ideas suggest themselves to her to take root. The most effective work in any mental hygiene attempt will always be in its preventive aspects.

ALL PATIENTS NOT AMENABLE

I would not, however, paint the picture too brightly. Although many problems can be prevented, and others helped, there are also those that do not readily lend themselves to modification. Difficulties that arise during pregnancy are often the result of fundamental attitudes that have been ingrained over a period of years. The so-called "immature" people fall in this group, the people who, in their emotional life, never reach that phase of development that we recognize as adulthood. As these patients approach motherhood, they are faced with a responsibility that they are incapable of meeting. The nurse can best help them by recognizing that such is the case and whenever possible by giving and securing the aid that they need.

I have tried to suggest how contact with the patient during the prenatal period can help to prepare her, and set the stage as it were for what is to follow.

With the ERA Nurses

ARKANSAS

The present ERA nursing program in Arkansas was instituted in June, 1934. Under this program nurses were assigned to the Social Service Division of each county in the State. In several of the counties more than one nurse was assigned.

Duties of the emergency relief nurses have been varied. The following is a list of the activities offered to relief nurses to be carried out as practicable and possible in the homes:

1. Educational: Lectures to groups, classes in first aid, home hygiene and care of the sick, exhibits, literature, demonstrations to the public, and soliciting voluntary service.

2. Home visiting service: Home visits, bedside care, (under direction of family physician), demonstrations to families such as giving baths, giving hot and cold packs, taking temperatures, doing dressings, etc., demonstrations to mothers on bottle feeding.

3. Communicable disease control: Placard of home on instruction from city or county health officer, isolation of patient, diet list prepared on physician's order, bedside care to patient daily if necessary, release of patient on permission of city or county health officer, instructing family and community in protection offered through immunization, sanitation and other precautions, instructions to patient and family as to dangers of complications of different diseases.

4. Prenatal and postnatal care: Placing patient under care of physician, regular visits to doctor's office, urinalysis frequently, preparing supplies for delivery, advice as to diet, exercise, rest and general care upon order of physician, bedside care and demonstration to attendant as to care of mother and baby, getting mother into doctor's office, at least once, for postnatal examination.

5. Sanitation: (coöperating with State Department of Health and U. S. Public Health Service) Inspection of well or spring used for household, construction of sanitary toilet for each home, screening of home, assistance in getting proper drainage of ponds near home, destroying mosquito breeding places, tin cans, barrels, etc.

One of the major activities of the emergency relief nurse's program has been the stressing of proper prenatal, neonatal, and postnatal care. Aware of the fact that our country has a high maternal death rate and at the same time knowing that approximately 50% of the children that are born are born to clients on relief rolls, it has been felt that the emergency relief nurses could do an untold amount of good in this field.

Each time that bedside nursing service is rendered in the home, we try to have some member of the family present in order that this may be a demonstration as well as actual service in the way of rendering comfort to the patient, as we feel that if we can teach the people how to care for themselves, we have done a lasting good in the community. All nursing service is given under the direct supervision of the attending physician. All activities in regard to preventive medicine are given in cooperation with the county health officer and the physicians in the county.

District conferences of the emergency relief nurses and State Supervisor of Nursing Service of the Emergency Relief Administration are held at various intervals over the State where the nurses receive instructions that are of interest to them in planning their program.

There has been a very close coöperation between the emergency relief nurses and the State Board of Health even though the ERA nurses are not attached to the State Board of Health, but to the Social Service Division of the Emergency Relief Administration.

The following is a summary of the various activities that were carried on by the emergency relief nurses from June 15, 1934 through March 31, 1935:

Educational: Lectures to groups 1,643; attendance 18,150; number classes taught home hygiene and care of the sick, first aid, etc., 570; exhibits 202; demonstrations to the public 464; number of bulletins distributed 38,723; number of organized groups giving voluntary service 474.

Home activities: Homes visited 59,960; bedside care 9,622; demonstrations to families 8,390.

Communicable disease control: Number of homes placarded under direction of city or

county health officer 467; number of patients isolated 928; number of patients released from quarantine under direction of city or county health officer 448.

Immunization: Number of clients immunized against typhoid 43,244; number of clients immunized against diphtheria 10,101; number of clients vaccinated against smallpox 5,710; number of anti-rabic treatments given 128. (All inoculations must be under supervision of licensed physician).

Prenatal and postnatal: Number of patients placed under care of physician 6,530; number of O. B. supplies made 3,958; number of baths and instructions given mother and baby 3,694; number of mothers to office for postnatal examination 2,118.

Sanitation: Number of homes inspected including well and spring 9,182; numerous homes screened; number of sanitary toilets constructed 711; number of homes destroying mosquito breeding places 1,754.

(MRS.) RUTH ANDERSON, R.N.
State Supervisor of Nursing Service, Case Work Department, Emergency Relief Administration

MINNESOTA

The State Relief Administration requested of the Division of Child Hygiene, of the Minnesota Department of Health, fifty public health nurses to be assigned work in the various counties as relief investigators. These fifty nurses were to be used as follows: Ten were assigned to assist physicians in examining clients for work relief; three were assigned as supervisors; the remainder as relief investigators. As such their work was similar to that of the usual social service trained investigators. As investigator-nurses, they were also to be especially responsible for cases in which health problems were in any way involved. On the basis of the findings of the CWS nursing project that had been in operation from January until April 1, 1934, the following points were felt to require the greatest emphasis and were made the basis for the public health nursing program:

A. Care of Mothers and Babies: The public health nurse uses her ingenuity and knowledge of community resources in arranging for medical and nursing care and securing supplies for maternal and infant care.

B. Nutritional Problems: The public health nurse is alert to symptoms of malnourishment and can be of assistance in securing medical advice or special help from the nutrition worker as is indicated. This problem is particularly urgent among the younger children and the expectant and nursing mothers.

C. Obvious Physical Handicaps: With present limited financial resources it is necessary for the nurse to recognize conditions which at the moment constitute a serious handicap for the child or a danger to the school or community and to bring them to the attention of the proper medical and relief authorities for correction.

D. Emergency Bedside Nursing: The public health nurse may demonstrate to the family or other responsible person the methods of carrying out the physician's instructions. Her service may be used to advantage in directing bedside nursing as a work relief measure. Good nursing care is necessary to keep down the incidence of reinfections, complications and prolonged illnesses. To protect those who are ill and require nursing care, any person engaged for bedside nursing must be approved by the local county nursing committee.

E. Communicable Disease Control Including Tuberculosis: The public health nurse assists the family physician and health officer with investigating and reporting suspected infectious diseases. She also assists communities with arrangements for applying recognized protective measures, *e. g.*, isolation technic, smallpox vaccination, diphtheria immunization, tuberculin tests, etc. Individual and group instruction of the value of such practices to the welfare of the community forms an integral part of the nurse's program.

The organization and coöperation of the local "nursing advisory committee" is being emphasized as a means of developing the above program. The successes that have been made have hinged upon the degree of interest of the County Relief Worker under whose immediate jurisdiction the nurse is placed, the Nursing Advisory Committee, and the ingenuity of the investigator-nurse.

The supervision of these services has been of an advisory nature directed by

the Division of Child Hygiene of the State Health Department and carried on through the three ERA nurse supervisors (later reduced to two), and the three regular advisory nurses on the Child Hygiene Division staff.

The first group of investigator-nurses to be assigned numbered 35 and included nurses who were trained and experienced in public health nursing. When positions opened up in the late summer there was a 40% turnover in personnel because the salary scale for investigator-nurses was placed at $85 and because most of these nurses were anxious to go back to the work for which they were especially prepared. During the year vacancies have been filled as qualified public health nurses have been available so that the number constantly employed has ranged between 30 and 35. Most of these nurses agree they receive valuable experiences in economics on the Emergency Relief staff.

The Nursery School nursing project was started in August in connection with the ERA program. Nineteen nurses were assigned to work on the nursery school staffs. Their responsibilities were primarily to supervise the general hygiene and sanitation of the schools, arrange for medical and dental examinations of each child enrolled at the school and secure the correction of physical defects, and to assist the nursery school teacher with the parent conferences.

The director of this project tried to assign nurses with a public health background, but since these appointments were governed by the financial status of the personnel, other nurses were included. Whenever possible these nurses were supervised by the local public health nurse, otherwise supervision was given by the field SERA and Child Hygiene supervisors.

At this writing, monthly reports have not been totaled so complete statistics cannot be given. It is evident, however, from month to month that the investigator-nurses have made contributions to the counties in which they have been assigned by having cared for the many health problems among the relief clients who have never been financially able to manage the corrections themselves. A recent comparison of twelve similar counties (six served by a regular public health nursing service and six served by the investigator-nursing service) indicates a strong possibility of developing an effective maternal and child health program in the latter type of service. This is largely due to the strategic position filled by the investigator-nurse in having the authority to insist on medical supervision and her close association with the families registered on relief.

Little has been said about the relative time used by the investigator-nurse in the two phases of her work. The need for so dividing her time was a necessary evil under the circumstances, and the resulting confusion—while variable—was as natural as it remains undesirable.

OLIVIA T. PETERSON, R.N.
Superintendent, Public Health Nursing, Division of Child Hygiene, State Department of Health

NEW YORK, N. Y.

Medical and nursing care is being extended to the indigent in New York City on a scale never before equaled.

The visiting nurse services of Henry Street Settlement, the Brooklyn Visiting Nurse Association, the North Shore (L. I.) Public Health Nursing Service and the Staten Island Visiting Nurse Association give care to the sick on home relief rolls under the direction of William G. Terwilliger, M.D., of the Medical and Nursing Service unit of the Home Relief Division, Emergency Relief Bureau. This Bureau is financed jointly by New York City (25%), New York State (25%), and the Federal Government (50%). The medical and nursing service is now about two years old, with a record of steadily increasing activity. This special service is made possible by certain rules and regulations of the Temporary Emergency Relief Administration which pays 75 per cent of the costs out of state and federal funds.

When this service was started, only ten to twenty calls were made a day. During the month of November 1933, there were 107,300 on relief rolls in the five boroughs, and 4,800 visits were made to the needy sick. In November

of 1934, 17,000 calls were made to 212,000 on relief rolls.

According to the April 1935 medical and nursing service report, thirty to forty calls are made daily and as many as 926 in some weeks by the nurses. There were approximately 239,332 persons on home relief rolls in April in the five boroughs. The total number of nurses' visits was 5,444 at a cost of $5,444.00—a dollar a call, and the average number of visits per family was 4. The largest number of visits was 3,760 for Manhattan. In the Bronx there were 464 visits by nurses; 1,048 for Kings; 144 for Queens and 28 for Richmond. Manhattan nurses' fees were highest with $3,760.00; Kings County, $1,048.00; Bronx, $464.00; Queens, $144.00 and Richmond $28.00.

An organization of 215 persons (April, 1935 figures) comprising an administrative staff, doctors, nurses and pharmacists also serve the home relief clients. The maintenance cost for the month of March was $21,568.74.

The question is often asked at the central office: "Who is eligible for home medical and nursing care?" Any person who is on the relief rolls, and is ill enough to be confined to his home, is eligible for this service. A doctor or nurse may be called simply by sending word to the Home Relief office in the precinct in which the patient lives—the same office to which he goes for rent, food and clothing. If the request is justified, a doctor is called, and if a nurse is required the nearest Visiting Nurse Service sends a nurse to care for the Home Relief patient on her regular round of duties. For the patient himself, according to Dr. Terwilliger, the validity of his request should be: "Would I call the physician if I were paying for him out of my own purse?"

A physician is assigned to the case within thirty minutes of application. Doctors are assigned in alphabetical rotation, unless a particular one is requested by the patient. But such a request is only granted if the physician has not received more than his average amount of work compared to others in his district. Calls, however, vary according to the amount of work in the precincts and the number of doctors registered. Every effort is made to maintain the relationship between family doctor and patient. At present there is a list of 3,262 accredited physicians. Physicians are paid two dollars for every home visit.

The type of case cared for may be classified as that of acute minor illness; an illness which is acute at onset, and confines the patient to home. The illness thus treated in the home must be of short duration, without complications, and of such nature that it may be treated in the home without endangering the other members of the family; for example, influenza or common head cold. Contagious diseases without complications are treated at home, provided there is adequate means to carry out the necessary quarantine. Maternity cases, with a normal history during previous births, and with apparently normal conditions at the time of present examination also are cared for by the medical and nursing service. It has been found that this work has materially lightened the burden of the hospitals which have been so overcrowded. There has also been a falling off of unnecessary ambulance calls.

Through the ministrations of nurses, members of the family are taught the simpler nursing duties, and the principles of correct diet. Thus, the service also becomes an educational service. During the time of the nurse's home visit she teaches other members of the family the fundamentals of health, hygiene and dietetics.

A combined medical and nursing committee is soon to be formed with members from each visiting nurse association with whom the bureau coöperates and Dr. Marjorie Knauth as members. They will meet occasionally to discuss the problem of Home Relief nursing.

WILLIAM G. TERWILLIGER, M.D.
Director, Medical and Nursing Service, Emergency Relief Bureau of New York City

Public Health Nursing in the Land of Sunshine

DOROTHY L. PLUMB

Florida's Nurse-of-the-Month

IT was with much enthusiasm and equally as much apprehension that I entered public health nursing in South Florida. I had no public health training to help me, only experience in industrial nursing and one year as Assistant Superintendent of a County Tuberculosis Sanatorium in northern Wisconsin, a far cry from South Florida! Because of the excellent supervision provided I have learned as I went along.

This particular county, Broward County, has never had any organized health program with county health nurses. The field offered to me was practically unbroken. The program was introduced by the State Board of Health, made possible by Federal Emergency Relief Funds. We have now a generalized program, including health supervision, maternity and morbidity services. It is our aim also to organize classes in home hygiene and care of the sick.

Our connection with the FERA perhaps makes our routine different from most official agencies. Our health work with relief clients is most satisfactory and quite simple. We know when we are called upon to visit a family receiving help from the FERA that we can obtain a doctor's services if necessary, and medicine if ordered by the doctor. We can also effectively arrange proper diets for health as well as for illness. When we are called upon to visit a family not on relief, and they cannot afford to pay for their medical care, it is very difficult and sometimes impossible to secure it for them. The problem of medical attention for our indigent sick is particularly serious among the colored people throughout the county. We cannot send our patients to the clinic—there is no clinic. We cannot send them to the Family Welfare Society—there is no Family Welfare. We cannot have them hospitalized for treatment, even when recommended by a physician because of the lack of hospital facilities.

WE HAVE VARIED PROBLEMS

OUR problems are many and varied here in the South Florida rural sections. Chief among them is the problem of the Negro and we have a very large colored population to reckon with. They are highly susceptible to disease, and as they work in the homes of the white people, they are constantly exposing both the adults and the children to infectious diseases. It is slow, tedious work teaching the colored folks health habits. Their housing problem is very serious—they live in unbelievably close quarters and have many, many children. They have practiced their old-time cures for generations and have fed their infants grits and salt pork and greens ever since they can remember. They listen to the white nurse, agree to feed the baby on sched-

ule, and agree to feed him the proper food, but somehow it is just too much effort for them to struggle with the infant when he begins to object to the change in his schedule. This is not only true of the Negro; there are many white people who take a great deal of attention and endless patience. Here is a field for the good nurse teacher!

Another problem which is all too familiar to us is that of hookworm disease. It will take much work on the part of the communities, as well as the physicians and nurses, to check the prevalence of this disease in our children, white and colored. A very great deal has been done since there have been adequate advice, instruction, and good literature available to all persons interested in this subject. In most instances there is a total lack of knowledge as to cause and treatment of hookworm disease.

I believe that the most interesting phase of our service is the maternity work. These patients, more than any other group, will listen to and also seek the nurse's advice, and will look forward to her next visit. I am fairly certain that this is because of the fact that most of the babies are born at home. The expectant mothers are so proud and so happy to have everything ready, clean, and complete for the babe. This is true of many colored patients, as well as white. Practically 75% of our colored maternity cases are delivered by registered, licensed midwives, also colored. These midwives are carefully supervised by the Supervisor of Midwives of the Florida State Board of Health.

ANEMIA—IN THE LAND OF SUNSHINE

South Florida should not have any pale, undernourished, anemic children, for it has something which cannot be excelled by any other part of the country. That is our year 'round summer weather. Winter and summer our children can play out-of-doors with their bodies exposed to the sun rays. We not only have the sun and warm weather all year, but also fresh vegetables and fruits. Citrous fruits in South Florida are not out of reach of even the poorest family. But here is a strange fact—we do have pale, undernourished, anemic children! The mothers do not seem to realize the value of what they have at their very back doors. This surely is another good field for the nurse teacher, and what greater thing can the county health nurses do than to teach health, teach prevention, teach and teach! It is truly a fascinating and interesting country for health work and we are pioneers in the field of public health nursing here in Broward County.

Institute on Maternity and Child Health

TWO HUNDRED and sixty-two nurses from 26 states and 5 foreign countries registered on June 10 for the week's institute on Maternity and Child Health held at the New York Hospital in New York City, under the auspices of the Maternity Center Association, the National Organization for Public Health Nursing and the New York Hospital. Of these 185 were public health nurses, 62 represented the institutional field and 15 came from other fields.

It was a full week, with lectures at both morning and afternoon sessions and demonstrations, exhibits, and moving pictures, question hours and round tables thrown in for good measure. And in spite of the full program and the lure of New York City's many attractions and the sudden onset of summer heat, the end of the week found a rather worn but still enthusiastic group eager to return home and put into working practice some of the new knowledge and old knowledge reënforced that had been absorbed during the week.

One of the high spots of the week was the banquet so graciously presided over by Mrs. Shepard Krech, President of the Maternity Center Association, with Dr. Howard W. Haggard, Professor of Physiology at Yale University and author of "Devils, Drugs and Doctors" as the speaker of the evening. Dr. Haggard chose as his topic "How to Present Child Health to your Community" and in his characteristic way made a plea for better "salesmanship" of health work.*

The two letters of appreciation that follow express how some of the nurses felt about the program.

I HAVE been wanting to write to you each day to say how very much we enjoyed and benefited by the Institute. From Sunday, the day of our arrival at Beekman Tower, to our departure on Saturday, everything seemed to us to be not only perfectly planned, but better, perfectly executed. We have one regret only, and that is that we have not the capacity to retain all of the interesting things we heard and saw, even with the aid of a notebook.

There are several things that I want to comment on. First, was the well thought out plan of carrying us to the meetings *on time*. Of course, we could have had no more comfortable Assembly Room anywhere. I am still marveling at the New York Hospital; it was my first visit to it and naturally I cannot refrain from thrilling at the completeness and beauty of it. Certainly the hospital staff was most gracious and hospitable. To be comfortable and not crowded when you are attending meetings that last a full week is not always accomplished.

I do think the committee should be congratulated on obtaining such successful speakers. It seemed to us that there were no more outstanding specialists in the country than we heard. Even if many of the discussions were not entirely new in content, to us, who are in the field far removed from the centers of research and study, it was stimulating to hear our programs emphasized by such splendid authorities. There was much that was new. I trust I shall never again say "venereal diseases".

I feel I must also say something of the exhibits. Not even at a National Convention, have I seen exhibits so practical and attractively displayed. Certainly, we got many ideas for our own exhibits, not only materials but the way they may be most effectively displayed.

RUTH PHILLIPS,
The King's Daughters, Norfolk, Va.

ONE leaves the Regional Institute on Maternity and Child Health with a feeling akin to that on Thanksgiving Day—a sensation of be-

*Excerpts from Dr. Haggard's paper will be published in a later number of this magazine as will also Dr. Nels Nelson's paper on "The Prevention and Control of Gonorrhea and Syphilis."

ing mentally stuffed with good things. After a period of digestion and relaxation one is ready to go forth with renewed energy, spreading the message to those unfortunates who were not able to attend.

The program covered new material of great interest and gave needed emphasis to the old that is valuable and has stood the test of time. The arrangement of the program was particularly satisfying, starting with the medical and nursing aspects of prenatal, postpartum and delivery care—discussions on syphilis, gonorrhea and tuberculosis, emphasizing the effects of these conditions on pregnancy—the acute communicable disease problem in the community, home and hospital—the growth and development of the child—parent education and lastly the handicapped child.

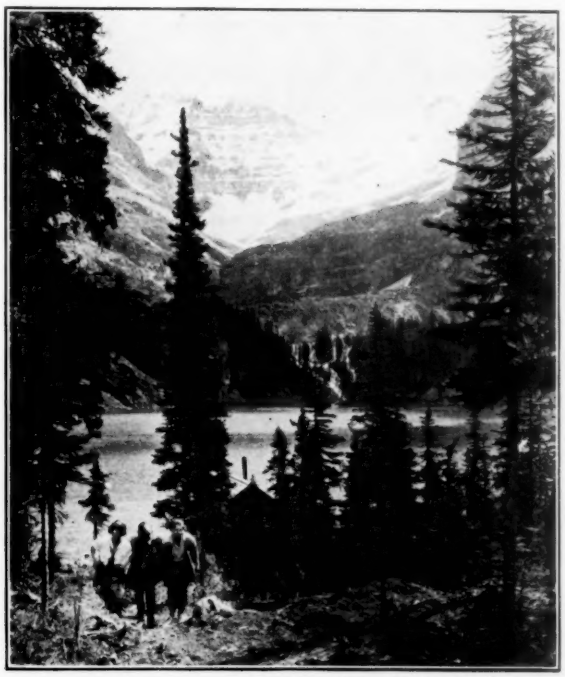
The demonstrations which were so thoroughly and attractively presented were of immense practical value, especially to those who, working in rural areas, are out of touch with the newer developments initiated in the metropolitan hospitals and nursing services. The readiness of the demonstrators to explain and answer innumerable questions was most gratifying.

The exhibits were an education in themselves. Time to study them all sufficiently was the only thing to be desired. The patient and repeated interpretation and explanation of all the details by those in charge gave an added value to one's observation.

The results of such an institute are difficult to estimate but undoubtedly its value will be demonstrated in many ways in all of the states and foreign countries represented. More power to the N.O.P.H.N. and the M.C.A. for more institutes and grateful appreciation to the New York Hospital for their gracious hospitality!

HELEN A. BIGELOW,
New York State Department of Health

A Beauty Spot on Lake Louise



Courtesy Canadian Pacific Railway

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

ELLA McNEIL TO JOIN N.O.P.H.N. STAFF

On July 22, Miss Ella McNeil will join the staff of the N.O.P.H.N. as a temporary assistant for the rest of this year. Miss McNeil is a native of Michigan, and received her nurse's training and B.S. degree at the University of Michigan in 1923. For several years she worked in the Child Health Demonstrations at Mansfield, Ohio, and Salem, Oregon, served as Assistant Director in the Division of Public Health Nursing of the Indiana State Board of Health, and since 1929 has been the Director of Public Health Nursing with the Southeastern Pennsylvania Chapter of the American Red Cross with headquarters in Philadelphia. In this position she had the supervision of 16 local services comprised of 43 nurses. She has also done postgraduate work at Teachers College, Columbia. We are delighted to welcome Miss McNeil to the N.O.P.H.N.

COMMUNITY CHESTS AND COUNCILS ANNOUNCES

At the request of the 1935 Mobilization for Human Needs, and through the courtesy of the National Organization for Public Health Nursing, two months' service by Miss Evelyn K. Davis, assistant director of the N.O.P.H.N. and chairman of the National Committee on Volunteers in Social Work, will be lent to the Mobilization, beginning August 15. Miss Davis will be one of the secretaries of the National Women's Committee which for the third year, under the chairmanship of Mrs. Franklin D. Roosevelt, will promote an interpretive program through the spoken word on behalf of privately supported social work. Miss Davis' experience and contacts with board members and volunteers all over the country will thus be used by Community Chests and Councils, the administrative agency for the Mobilization in which the N.O.P.H.N. and 34 other national agencies take part.

HONOR ROLL

The following is a list of agencies holding 100 per cent nurse membership in the N.O.P.H.N. enrolled during June. For those already enrolled for 1935 see the previous numbers of this magazine beginning with March. Asterisks indicate the number of years an agency has held 100 per cent membership.

ALABAMA
*Lamar County Health Department, Vernon

CONNECTICUT
****Visiting Nurse Association, Waterbury

ILLINOIS
****Chicago Tuberculosis Institute, Chicago

IOWA
***Visiting Nurse Association, Sioux City

MAINE
**Mt. Desert Chapter, American Red Cross, Northeast Harbor

MASSACHUSETTS
**District Nursing Association of Barnstable, Yarmouth and Dennis, Hyannis
***Visiting Nurse Association, Lynn
**Society for District Nursing, Worcester

MICHIGAN
**Monroe County Chapter, American Red Cross, Monroe

MINNESOTA
****Metropolitan Life Insurance Nursing Service, St. Paul

NEW HAMPSHIRE
***District Nursing Association, Portsmouth

NEW JERSEY
****Monmouth County Organization for Social Service, Red Bank

NEW YORK
***North Suffolk Chapter, American Red Cross, Huntington
***Visiting Nurse Association, New Rochelle
**Association for Improving the Condition of the Poor, New York City

OHIO
*Metropolitan Life Insurance Nursing Service, Akron
*Red Cross Nursing Service, Barberton

PENNSYLVANIA
***Henry Phipps Institute, Philadelphia
***Negro Nursing Bureau, Philadelphia
*Visiting Nurse Association, Scranton
*Community Nurse Association, Whitford

TENNESSEE
*Metropolitan Life Insurance Nursing Service, Knoxville

TEXAS
****City Health Department, Fort Worth

J. V. S. APPOINTMENTS

The increase in activity in public health nursing placement has continued through the summer. Among the appointments which have been made through Joint Vocational Service, the following are of especial interest:

Ruth Telinde, formerly Henry Street Visiting Nurse Service Supervisor, as Educational Director of the Instructive Visiting Nurse Society, Washington, D. C.

Helen C. Brennan, for vacation relief as Vocational Secretary in Public Health Nursing, Joint Vocational Service, New York City.

Myrtle Stickler as Educational Director in the Nursing Service of the Palama Settlement, Honolulu, T. H.

Mildred B. Oberg, staff nurse, East Harlem Nursing and Health Service, New York City.

N. Helen Phelps, scholarship student in health education this past year at the Massachusetts Institute of Technology, as Health Director and Supervisor of the Health Department in the State Normal University, Las Vegas, New Mexico.

Margaret A. Gordon, in charge of the Visiting Nurse Association under the Woman's Club in Montpelier, Vermont.

Noreita Alvis as County Nurse for the Clarke County Visiting Nurse Association, Berryville, Va.

Bertha B. Ferron and Miss Mary Leonard as staff nurses, Northern Westchester County District Nursing Association, Mt. Kisco, New York.

Helen U. Carew as Medical Social Worker, Babies Hospital, New York City.

Elizabeth Hanson, as Assistant Superintendent, Visiting Nurse Association, Scranton, Pennsylvania.

The following nurses in summer substitute or summer camp positions:

Mrs. Bessie F. Wildman, as assistant to the director of admissions, St. John's Guild, New York City.

Bluma B. I. Oppenheim, as camp nurse, Camp Rainbow, Croton-on-Hudson, New York.

Doris Bauwens, as camp nurse, Episcopal City Missions Convalescent Home and Camp, West Park, N. Y.

Mrs. Mary S. Hitchcock, as temporary assistant chief nurse, Wave Crest Convalescent Home, Far Rockaway, N. Y.

Mrs. Lee Moerkerk Fuhr, as summer relief nurse, New York Child's Foster Home Service, New York City.

Joint Vocational Service has rendered assistance in the placement of several nurses, among them:

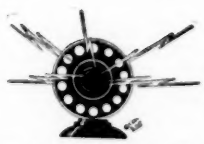
Ruth Kahl, as Assistant Superintendent of the Instructive Visiting Nurse Association, Richmond, Va.

Other placements heard of by Joint Vocational Service include:

Frances Henry as college nurse, Fort Hays State College, Hays, Kansas.

Carolina Falls, as supervisor of the health division of the Lenox Hill District of the A. I. C. P., New York City.

BROADCASTING A NEW N.O.P.H.N. POSTER



A NEW colorful poster especially prepared for the N.O.P.H.N. is now ready for Fall drives and fund-raising. The picture portrays the appealing figure of a sick child in bed with a blue-uniformed public health nurse giving care. The poster has been reproduced from a painting in eight colors, size 16 x 20, and is available both in cardboard with easel back, and in paper. No caption or text appears on the poster, and space has been allowed for a local message or name of association.

Prices:

Paper, single copies 20 cents each; 1 dozen or more, 15 cents each.
Cardboard with easel back, single copies 30 cents each; 1 dozen or more, 20 cents each.
A discount of 40 percent is allowed on quantities of 50 and over.

• The annual meeting of the National Association of Colored Graduate Nurses will be held in New Orleans August 13-15. The first day will be devoted to the problems of the student and the school of nursing with students participating in the discussion. An institute is planned for the last two days on such topics as student affiliations, child welfare, the use of records, etc. Those presiding at the sessions will be Mrs. Louise Leubers of Chicago, Mrs. Margaret H. Creth of New York, Chairman of the Institute, Mrs. Mabel K. Staupers, Executive Secretary of the N.A.C.G.N., Mrs. Daisy Dickerson of Chicago, and Miss Mabel C. Northcross of St. Louis. Mrs. G. Estelle Massey Riddle is President of the organization.

• At the 30th Annual Convention of the Washington S.O.P.H.N. held in Walla Walla in May, the following officers were elected: *President*, Mary Pritchard, Bellingham; *Vice President*, Edna Mason, Spokane; *Secretary*, Elizabeth Brady, Seattle; *Treasurer*, Anna Carlson, Mt. Vernon.

• At the spring meeting of the Board Members' Organization of the Connecticut Public Health Nursing Associations in Meriden, the morning session was devoted to two talks—one by Miss Rowena Belden, R.N., of the State Department of Health, the other by Mrs. C.-E. A. Winslow, president of the New Haven Visiting Nurse Association. Miss Belden discussed venereal diseases from the public health standpoint, suggesting ways in which board members might help in developing a sane attitude toward this problem. She also stated that the public health nurse was invaluable in case finding and case holding. Mrs. Winslow presented a sketch showing the contrast between a public health nursing visit in the early days and one today. She followed with a short talk on the value of the National Organization for Public Health Nursing to public health nursing, and suggested that it was time to take stock to see just what the N.O.P.H.N. meant to its individual associations. Following Mrs. Winslow's talk many members representing various VNA's told of ways in which their organizations had benefited in using the many services offered by the N.O.P.H.N. The afternoon session was devoted to three round tables for discussion of medical advisory committees, nursing committees and how to secure good board members.

• To pay her homage for forty years of service in the field of public health nursing, the friends and colleagues of Harriet E. Fulmer, Supervisor, Rural Public Health Division, Cook County, (Ill.) Bureau of Public Welfare, gathered at dinner at the Blackstone Hotel in Chicago on May 15, 1935. The testimonial presented to Miss Fulmer by the First District of the Illinois State Nurses' Association reads in part:

> "In recognition of the forty years of faithful service in the field of Public Health and Social Welfare in the City of Chicago and the Commonwealth of Illinois, your fellow citizens pay tribute to your untiring labors for the betterment of society.
>
> "In appreciation of the wise counsel, devoted leadership and dynamic spirit in behalf of Nursing, expressed through State and National organizations and personal endeavor, your colleagues bear witness to your spontaneity, resourcefulness and courage."

• The American Medical Association at its annual meeting held recently in Atlantic City voted to appoint a special committee to study birth control and report next year. The action was the first the organization has taken on this question.

• The American Red Cross will present a scholarship to an American nurse for the international course offered by the Florence Nightingale International Foundation. This is the first scholarship made available to an American Red Cross nurse since the Foundation was inaugurated in July 1934.

• From England we learn of the retirement of Sir George Newman from the Ministry of Health, of which he was Chief Medical Officer since 1919. Sir George was very active as a pioneer in public health work in England. He is succeeded by Sir Kingsley Wood.

• At the National Conference of Social Work meeting in Montreal, Evelyn K. Davis, of the N.O.P.H.N., was re-elected chairman of the National Committee on Volunteers in Social Work for one year; Miss Leah Feder, assistant professor of social work at Washington University, vice-chairman for one year; Mrs. Clarence Caspary, of Philadelphia, re-elected to another three-year term of membership.

• Summertime is travel time, and many of its members and friends have been visiting the N.O.P.H.N. offices, while on vacations and "leaves."

• The Rockefeller Foundation has made a travel grant to Naomi Deutsch, director of the public health nursing course at Berkeley, California, to observe and study public health work in urban and rural communities throughout the United States. She will be traveling the greater part of the summer.

• Escuela de Enfermeras has recently been opened at Valparaiso, Chile, as the largest nursing school in Latin America. The school building is six stories high and accommodates 60 pupils. A smaller building houses classrooms, laboratories, lecture hall and offices. Other sections of the school provide for kitchens, laundry and a home for the directress. The students will be enrolled from applicants between 20 and 30 years who must have reached the fifth year in the Chilean secondary school system, and the future Chilean nurses will take cookery courses and diet studies. On the top floor a model hospital will be installed, where the students will care for a number of local patients. Until recent years, Chilean nursing in the large public hospitals was carried out by nuns and Sisters of Mercy.

• The Michigan Board of Registration of Nurses will hold an examination September 10th and 11th for graduate nurses, September 10th for trained attendants, at The Peter White Library, Marquette. All applications with fees must be on file in the office of the Board of Registration of Nurses, 200 Hollister Building, Lansing, not later than August 26th. Mrs. Ellen L. Stahlnecker, R.N., Secretary. They will also hold an examination September 19th and 20th for graduate nurses, September 19th for trained attendants, at the Book-Cadillac Hotel, Detroit. Applications with fees to be on file not later than September 3rd.

OCTOBER MEETINGS

September 30-October 4 — National Recreation Association, 21st Congress, Chicago, Ill., Hotel Sherman.

October 14-18 — Twenty-fourth Annual Safety Congress, National Safety Council, Louisville, Ky.

October 28-31 — Eighteenth Annual Meeting, American Dietetic Association, Cleveland, Ohio. Dean Marion D. Howell of Western Reserve will speak on "An Appraisal of the Teaching of Dietetics from the Nursing and Educational Point of View."